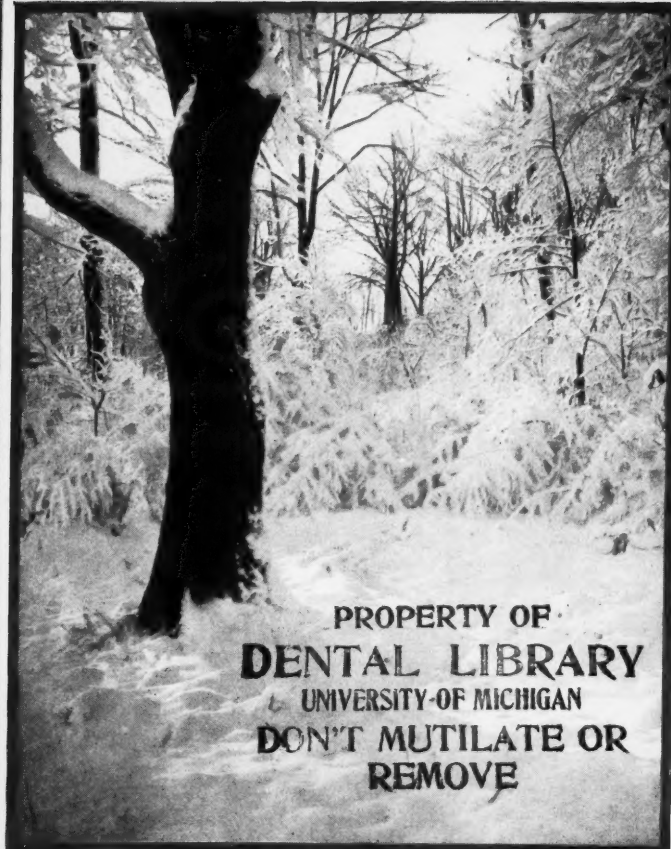


# THE DENTAL DIGEST



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**MARCH 1925**

VOL. XXXI, NO. 3

EDITED BY  
GEORGE WOOD CLAPP, D.D.S.  
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CANDLER BLDG. TIMES SQUARE  
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# THE DENTAL DIGEST

GEORGE WOOD CLAPP, D.D.S., EDITOR

Published monthly, by THE DENTISTS' SUPPLY COMPANY, 220 West 42nd Street, New York, U. S. A., to whom all communications relative to subscriptions, advertising, etc., should be addressed.

Subscription price, including postage, \$1.00 per year to all parts of the United States, Philippines, Guam, Cuba, Porto Rico, Mexico, and Hawaiian Islands. To Canada, \$1.40. Great Britain and Continent, \$2.75. Australia, \$3.25. To all other Countries, \$1.75.

Articles intended for publication and correspondence regarding the same should be addressed EDITOR DENTAL DIGEST, Candler Bldg., Times Square, 220 West 42nd Street, New York, N. Y.

The editor and publishers are not responsible for the views of authors expressed in these pages.

Entered as Second Class Matter, at the Post-office at New York City, N. Y., January 29, 1909, under the Act of Congress, March 3, 1879.

## OUR COVER THIS MONTH

It is known that some months of the year can be outlined in pictures. It would not be hard to guess the particular month our COVER PICTURE suggests. Ice-covered trees and shrubbery, a bleak-looking landscape, and all the amazing conditions that lie between extreme cold and unseasonable hot spells—that's March in New York and all points north! It's in March that an occasional sunny day causes one to forget winter and think of the coming of balmy spring. And just when you are feeling gay about the prospect of pleasant weather, old March sets up a howl—the wind blows, snow and sleet chase you to cover, and you think thoughts that you couldn't find in the Scriptures.

What with groundhogs, spring poets, weather prophets, professional forecasters, rheumatiz vizardis, etc., etc., we ought to be better posted on this climatic stuff. We are often inclined to think well of March, but we only deceive ourselves in doing so. Probably the poet slips us the correct tip when he writes, "Tis far to the time of the bluebird and thrush; the ice in the city is turning to slush, and singers of Spring should be still and discreet, till sunshine is hitting both sides of the street."



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# THE DENTAL DIGEST

Vol. XXXI

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## Tooth Form and Function\*

By Max Giesecke, D.D.S., Denver, Colo.

The slogan for this meeting is "Preventive Dentistry," including those branches of dentistry which tend to remove the cause of disease in the mouth and so promote the health of the entire body. The first step in this direction is the proper feeding of the mother as well as of the infant. Then the teeth must be observed individually and collectively at regular intervals to see that their proper function is maintained. It is the object of this paper to point out the important features of tooth form and its relation to function and periodontal health. If our teeth were normally formed, normally occluded and given a chance to function normally, there would be little need for dental services. Such conditions very rarely, if ever, exist, so it behooves us to use every effort and opportunity to better the conditions we find in the mouth.

Through the ages nature has striven to improve upon her work, making countless changes to develop the present-day fauna, each type differing from the other and being adapted to its environment. Thus, too, the teeth have been developed from the ossified dermal plates and small, cone-shaped teeth found in the mouths of the Silurian and Devonian fishes to the highly specialized types of the Herbivora, Carnivora and Omnivora. The first function of teeth was probably prehension, and this is still the only function in some fish and reptiles, though this is of the least importance in man. Some fishes and reptiles have teeth supplied in endless succession; when one is lost another rises to take its place. Others have heavy "nutcracker" jaws of hard, bony material with which to crack the shells of mollusks and crustaceans upon which they feed.

In the Herbivora the beaver (a rodent) furnishes a good example of highly specialized teeth (Fig. 1). The central incisors are long, curved teeth which grow from persistent pulps. They have a heavier, denser plate of enamel on the labial surface than on the lingual so that in use the lingual portion wears faster than the labial, producing a sharp, chisel-like edge with which to cut the trees and shrubs from

\* Read before the Colorado State Dental Association, Glenwood Springs, Colo., June 20, 1924.

which the beaver gets food and material for dams. Continuous growth preserves the length of the tooth and so insures the perfect functioning of the cutting edge. The elephant also has developed specialized incisors. The upper incisors, which serve as formidable weapons of offense and defense, are long, pointed tusks of dentine with very little, if any, covering of enamel. The four or eight remaining molars have broad, flat surfaces with alternate folds of enamel, dentine and cementum. Through wear this unequal density produces a roughened surface which is exceptionally well adapted for grinding. This is the type of tooth found in the molars of all Herbivora. The temporo-mandibular articulation is open, allowing extreme lateral movement.

In the Carnivora the jaws are limited to vertical movements and

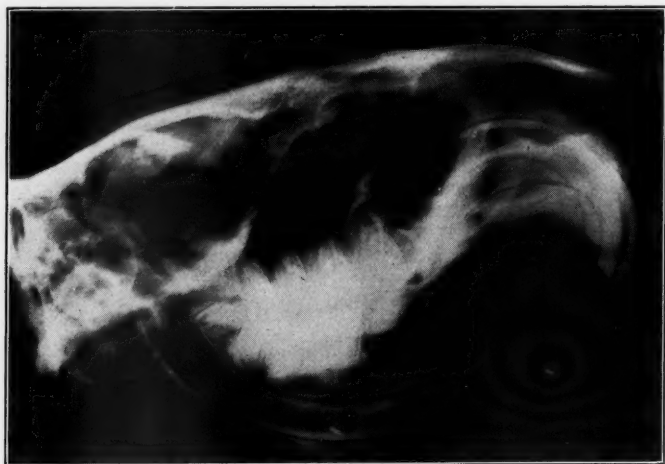


Fig. 1

X-Ray of beaver head, showing specially developed central incisors. (Dr. G. R. Warner.)

the teeth consist largely of points and blades well adapted to prehension and crushing. Just occlusal to the gingiva, the soft tissues are protected by a prominence which deflects the particles of bone, etc., in the food as it passes from the tooth surface, striking the soft tissues at a tangent. Here we have the cuspids developed to serve as a more efficient weapon in battle as well as in prehension of food. A striking example of this type of specialization was found in the sabre-toothed tiger, which is now extinct. (Fig. 2.)

It is, of course, the omnivorous type of tooth that concerns dentists, and here the food is the greatest factor in determining the type of jaw

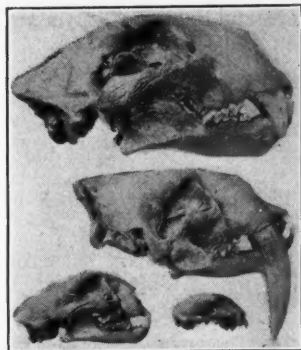


Fig. 2

Carnivoral skulls. Lion (at top), sabre tooth, mountain lion and lynx. All figured on the same scale. (Museum of Los Angeles County.)

and teeth. The consumption of both animal and vegetable food must be provided for. This requires a mechanism allowing for all the various movements of the jaws during mastication. The teeth must be adapted to function in these different movements, which are classified as follows: (1) prehension, (2) incision, (3) crushing, and (4) trituration or grinding. In prehension and in the first part of incision the teeth meet incisally, grasping a portion of the food and, when the hands pull the food away, placing a strain upon the crowns and incisor teeth, giving them a labial inclination. This prehensile type of jaw is not often found in the more civilized races but is still quite common in the more primitive people unfamiliar with the use of knife and fork. (Fig. 3.) The second part of incision is a scissors-like action during

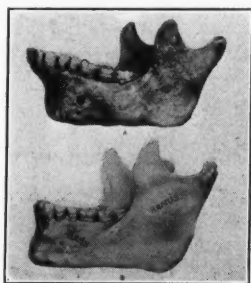


Fig. 3

Prehensile type of jaw above. Note labial inclination of lower incisors compared with lower mandible. (Cryer.)

which the lower incisors and jaw are drawn upward and backward. This function has also been largely eliminated by the use of the knife and fork and is perhaps now used only in eating raw fruits. Crushing is performed by a strong vertical pressure of the lower posterior teeth against the uppers. This is a very beneficial action in that it has a tendency to expansion and also stimulates the deeper structures which form the attachment and support of the teeth. Trituration is a movement of the mandible from without inward. It is the prevailing movement used by civilized man today, but unfortunately has a tendency to contract rather than expand the arch (Pickerill).

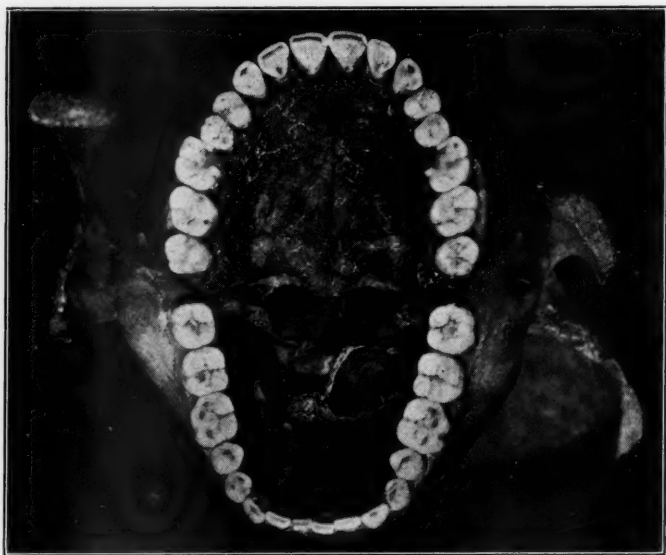


Fig. 4

Occlusal surfaces of maxilla and mandible. (Dr. A. H. Ketcham.)

#### THE MOUTH AS A WHOLE

*Arrangement of the Teeth.* The teeth of the maxilla are arranged in the form of a semi-ellipse. The incisal edges of the six anterior teeth form a continuous curve which is extended along the buccal cusps of the bicuspid and molars in a more or less straight line to the distal of the third molar. (Fig. 4.) The aggregate mesio-distal diameter of these teeth is slightly greater than the lowers, so we find the upper third molars projecting distally to the lower thirds. In the mandible we have a similar but slightly smaller curve or arch which

allows the buccal cusps of the lowers to occlude lingually to the buccal cusps of the uppers into the sulci formed by the buccal and lingual cusps. The anterior teeth also occlude lingually to the uppers and in this way the cheeks and tongue are protected in the act of biting by being held away from the actual occlusal contact and thereby preventing a pinching or crushing.

*Inclination of the Teeth.* The long axes of the upper posterior teeth have a buccal with a slight mesial inclination, and the anterior teeth are tipped mesially and labially. In the lowers the anteriors have the same inclination, perhaps slightly less, while the posterior teeth are tipped mesially and lingually. (Fig. 5.)

#### CONTACTS AND EMBRASURES

All teeth have a greater mesio-distal measurement near the occlusal surfaces than at their necks. In this way they have a contact with the adjoining teeth near the occlusal surface, which offers considerable

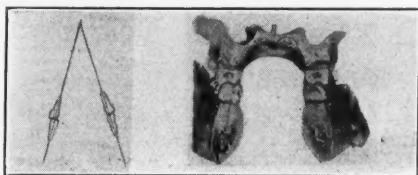


Fig. 5

Transverse section of jaw in molar region showing inter-articular inclined planes. (Cryer.)

approximal support through the action of the transeptal fibers. These points of contact are found along the incisal edge of the anterior teeth and along the buccal cusps of the bicuspid and molars, producing the buccal and lingual embrasures. The latter are usually the larger although sometimes the molar contacts are found further lingual, in which case the lingual embrasure may not be much larger than the buccal. The function of the contact is to prevent food from being forced against the septal tissue, and the embrasures are to allow the excursion of food to clean well into the approximal spaces while passing into the buccal and oral cavities where it is forced back between the occluding teeth by the action of the cheek and tongue.

#### THE INTERPROXIMAL OR SEPTAL SPACES

The mesio-distal contacts of the teeth leave V-shaped spaces between the teeth with the base on the alveolar process known as interproximal or septal spaces large in the molar region and narrower in the incisal

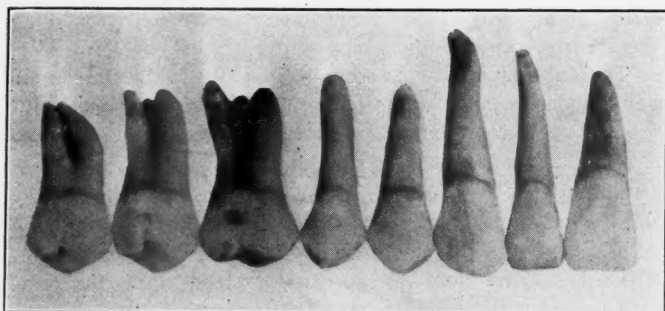


Fig. 6

Interproximal or septal spaces. These should be maintained in order to insure a good blood supply to the septal tissue.

region. (Fig. 6.) These spaces are normally filled by the septal tissue and should be maintained in order to insure a good circulation of blood for these tissues.

#### HEIGHT OF CONTOUR (FRIESELL)

The height of contour is a bulge or protuberance found on the axial surface of a tooth and may be represented by a line each point of which is that farthest removed from the center or long axis of the tooth. (Fig. 7.) It is the dividing line between the clean and unclean surface of the tooth. The occlusal portion receives the scouring action

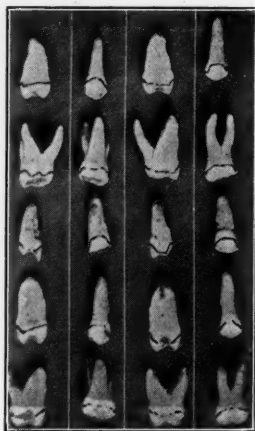


Fig. 7

Height of contour. (Friesell.) Black line shows points of greatest distance from long axis of tooth.

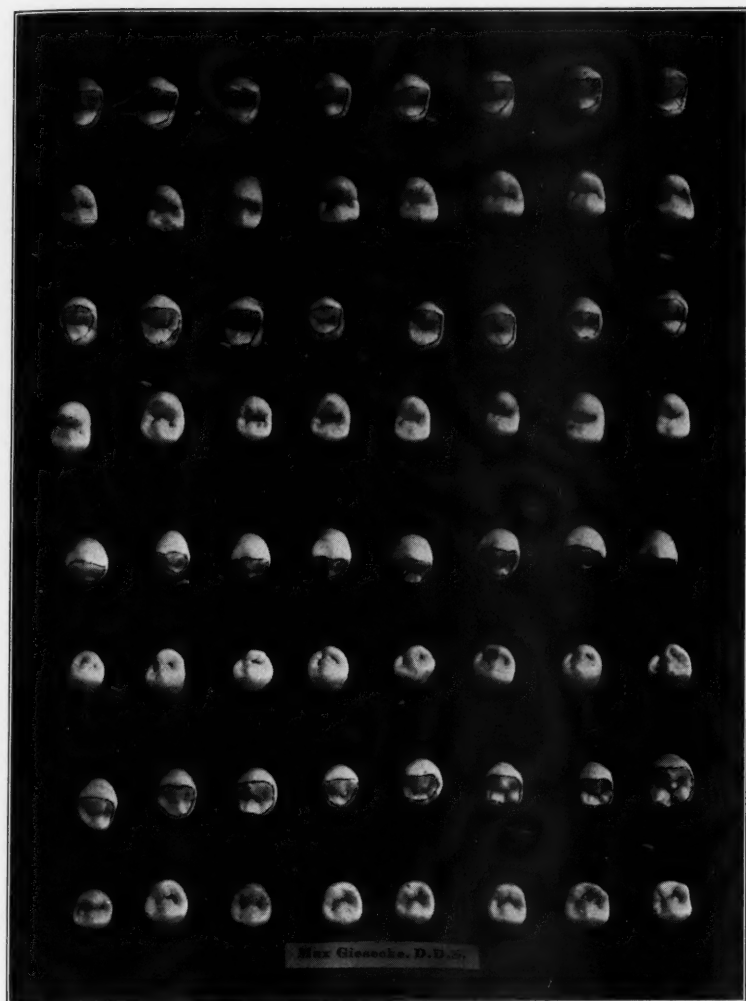


Fig. 8

Occlusal constriction and marginal ridges on bicuspid. The surface lying between the largest diameter of the tooth (height of contour) and the marginal ridges, which are marked with ink, is known as the "occlusal constriction." There is a decided tendency in restoring occlusal surfaces to include too much area within the borders of the marginal ridges and so produce an occlusion trauma.



of the food in mastication and is therefore relatively immune to caries. The gingival or protected portion is a susceptible area. The function of the height of contour is to deflect the food from the crest of the marginal gingiva and to have it strike the body of the gingiva at a tangent, preventing injury to this important tissue.

#### OCCUSAL CONSTRICTION AND MARGINAL RIDGES

The portion of tooth between this height of contour and the occlusal surface of bicusps and molars is known as the occlusal constriction and its function is to lessen the resistance of the tooth in erupting and also in entering food. (Fig. 8.) This should be carefully considered in making restorations of all kinds.

Where the occlusal constriction meets the occlusal surface we have the marginal ridge. Mesially and distally its function is to guide food away from the contact point upon the occlusal surface and also to guide portions into embrasures, some even passing through the contacts. The occlusal surface is bounded by the marginal ridges and is composed of cusps, sulci and fossae. Between these cusps, and forming outlets for the sulci and fossae, grooves are found which provide for the escape of food into the embrasures and upon the buccal and lingual surfaces.

#### SOFT TISSUES

Surrounding the necks of the teeth and a portion of the enamel we find the gingiva, which also fills the interdental spaces. The function of this tissue is to protect the pericementum and the crest of the alveolar process from both infection and trauma. The cemental gingiva, which is attached to the neck of the tooth also, sends fibers to the marginal gingiva, which covers a portion of the enamel near the neck of the tooth but is not attached to it. This tissue terminates in a very thin knife-like edge, which in turn has to be protected from trauma by the contour and position of the teeth. This is accomplished by diverting the food just past the crest of the gingiva and allowing it to strike the body of the gingiva at a tangent.

#### RESTORATIONS

When a tooth has been lost in whole or in part, it is desirable that it be restored promptly before any further damage is done and in order to prevent still more impairment of function of the remaining teeth as well as lateral drifting and elongation. To bring about a satisfactory restoration it is essential that the dentist have a thorough conception of anatomical tooth form and that he apply this knowledge. (Fig. 9.) Good judgment, of course, should be exercised. The existing conditions in the mouth should be noted and the operator governed

accordingly. It is good practice in restoring a tooth to note the corresponding tooth on the opposite side of the jaw unless it also has been destroyed or mutilated. It would be ridiculous to carve cusps such as would be found in the tooth of a child of twelve for an adult of sixty whose cusps show considerable wear. A good guide for locating marginal ridges may be obtained by marking with a soft pencil the tooth just mesial or distal, or both, to the one being operated upon, which will reduce the tendency to overocclude. The filling should be carefully checked for any lateral or occlusal strain, and the patient should not be dismissed until he is sure that a normal occlusal relation has been established with the opposing teeth. Too frequently patients are dismissed while still conscious of pressure and told, "Oh, that'll wear down all right after you have used it a while." But it does not

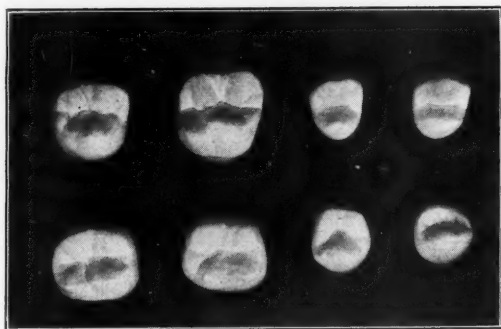


Fig. 9

Large reproductions of "Tooth Form," modeled in clay and reproduced in plaster. Measurements were taken from photographic enlargements (five diameters) made of natural teeth.

always do so. Gold is malleable and will flow under occlusal stress. The strain will continue and many times an irritation is produced which may cause pulpitis. Usually pericementoclasia is the result, often with deep pocket formation.

Therefore, a restoration should restore the original anatomical form as nearly as possible, and the occlusion with the opposing teeth, as well as the mesio-distal relation with the adjoining teeth, should be maintained. They should be mechanically efficient not only for mastication but in the protection of the periodontal tissues.

California Building.

## The Principles and Practice of Administering Nitrous Oxide—Oxygen and Ethylene Oxygen\*

### *Second Article*

(EDITOR'S NOTE.—Logical sequence in these articles would call for the presentation of nitrous oxide-oxygen technic here. But so many anesthetists are interested to learn about the characteristics and use of ethylene that it seems wise to interrupt the sequence and present this information now.)

### HINTS ABOUT USING ETHYLENE

Ethylene, which has been coming into increasing use as an anesthetic during the last year or two, is supplied to the anesthetist in tanks identical with those which contain nitrous oxide. It is employed in about the same manner as nitrous oxide, but certain precautions are important.

Before beginning the administration of ethylene any electric lights which are to burn during the anesthesia should be turned on. No electric lights should be turned on or off and no motor allowed to run during the anesthesia, since these may cause a spark, which, under certain conditions, may cause any ethylene vapor in the air of the room to explode.

During the administration circulation of fresh air should be maintained in the room. Ethylene cannot be exploded when it is in the tank, but in concentrations of from 5% to perhaps 35% it is explosive. It may take the form of strata in a room, and if a spark occurred in a stratum showing such a concentration, a sheet of flame would shoot across the room. This has occurred in dental offices in several cases from sparks of a fan motor, but it is reported that no damage was done. It would require several hours of continuous operating in a room 14 x 16 feet, with poor air circulation, to produce a concentration of 5%.

Ethylene has some advantages as an anesthetic, especially with difficult types, such as the stimulated type, which does not succumb readily. Ethylene will take care of some cases that are beyond nitrous oxide, but there are cases which even ethylene will not handle without proper premedication. Such a case will be referred to in the eighth article of this series, in which types of patients are described.

Ethylene stands between nitrous oxide and ether in the degree of relaxation it produces. The blood remains pink during ethylene anes-

\* These papers are based on a clinic given before the Florida Dental Anesthetists' Society at Orlando, Florida, December 17, 1924, by J. A. Heidbrink, D.D.S., Minneapolis, Minn.

thetia. The color changes characteristic of nitrous oxide anesthesia are lacking.

Under ethylene the reflexes in the throat are less active than under nitrous oxide-oxygen. In surgical anesthesia with nitrous oxide the reflexes in the throat usually remain sufficiently active so that if any mucous passes back into the throat the patient will cough it out before it gets into the trachea. In surgical anesthesia with ethylene, because of this absence of reflexes, the patient may be unable to cough until the anesthesia lightens during awakening. If blood and mucus have been permitted to pass back, they may get into the trachea and coughing during awakening may be severe. Because of this dulling of the reflexes and the fact that ethylene increases the flow of mucus, careful throat-packing is especially important in ethylene anesthesia.

The greater muscular relaxation in ethylene anesthesia produces two closely related effects concerning which the anesthetist should be informed. The mandible more readily drops back or is forced back by the pressure of operating upon it, and the muscles of the throat are more likely to collapse inward and restrict the air passages. The muscular relaxation is not likely to prove troublesome unless the mandible drops back or is forced back. If the mandible is held forward during the operation, preferably by forward pressure on the posterior margins of the rami near the angles, the air passages will usually be kept free. Simple methods for restoring respiration will be described in the article which gives the technic for administering nitrous oxide-oxygen.

Ethylene has a pungent odor, rather disagreeable at first, but after one or two inhalations the patient does not notice it.

Because of the greater relaxation patients are carried in a quiet anesthesia more easily with ethylene than with nitrous oxide, but the breathing should be even more carefully watched because the other symptoms are less pronounced. Ethylene is also a little more dependable than nitrous oxide for long operations, especially for difficult patients. Because ethylene is more powerful it gives a wider anesthesia range. Recovery from ethylene anesthesia is quite similar to that from nitrous oxide anesthesia, but a little slower.

#### NITROUS OXIDE AND ETHYLENE IN COMBINATION OR SEQUENCE

Some anesthetists administer nitrous oxide and ethylene in combination. This is made possible by a synergist attachment now made for use with any nitrous oxide and oxygen apparatus which enables the anesthetist to administer nitrous oxide and ethylene at the same time or to change readily from one to the other. With this attachment it is impossible to mix the two gases in the tanks. The switch from

nitrous oxide to ethylene, or vice versa, can be equally well accomplished by placing a tank of each gas in the hanger yokes on the nitrous oxide side and being careful that both tanks are not open at the same time so that the gases can mix in the tanks. Anesthetists are of the opinion that if these gases mix in the tanks, both tanks must be thrown away, but Dr. Heidbrink does not understand why this should be.

When making the switch from nitrous oxide to ethylene, the center valve on the apparatus used in this clinic should be moved to indicate a flow of two gallons of ethylene per minute, and the oxygen should be increased to 10%. As with nitrous oxide, there may be indications for further increases in the oxygen percentage as anesthesia progresses. On apparatuses the dials of which are calibrated for nitrous oxide, the indication of flow is not correct for ethylene, and the increase in the percentage of oxygen is apparent rather than real because ethylene flows through a given aperture more rapidly than does nitrous oxide, so that while the indicator shows two gallons per minute the ethylene will be flowing at a rate approaching three gallons per minute and the increase in oxygen, from "7" to "10" on the dial, will be merely proportionate to this more rapid flow.

Anesthetists have been misled into thinking that ethylene requires a much higher percentage of oxygen than nitrous oxide, when the fact is that the greater volume of ethylene which flows through a given aperture requires a corresponding increase in the volume of oxygen.

To induce anesthesia with ethylene, set the center valve to indicate a flow of two gallons per minute and the oxygen indicator at 10%. Adult patients will reach the surgical stage of anesthesia in about the time they would require under nitrous oxide-oxygen—one minute and forty seconds. Many patients may be carried in anesthesia throughout the operation without increasing the oxygen above 10%. Others may require up to 25% to avoid undesirably deep anesthesia.

For children 85% ethylene and 15% oxygen are given continuously in a volume of two gallons per minute until the desired plane of anesthesia is reached—usually between one minute, ten seconds, and one minute, thirty seconds, depending upon the age and size of the child. When the desired plane of anesthesia is reached, the oxygen is increased to 20%, and this is given continuously during the carrying period. In some cases, as in persistent mouth-breathers, it may be necessary to reduce the percentage of oxygen, while in other cases it may be necessary to increase the oxygen up to 25%.

*(To be continued)*



## A New Type Attachment

By Carl A. Heller, New York, N. Y.

The following case came to my attention some time ago and, as it was a typical example of one of the stumbling blocks in dentistry, I thought that the readers of *THE DENTAL DIGEST* would be greatly interested in the description of a new type of attachment that will overcome the failure to keep in place a denture with anchorage on only one side.

The model was sent to me by a New Rochelle dentist and had the four upper anteriors in place and the first molar on the left side remaining. He suggested a cast gold denture with some type of attachment to aid suction in keeping the denture in place.

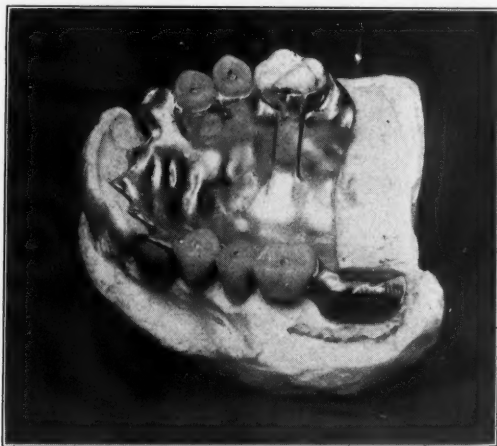


Fig. 1

A cast clasp on the molar and wire clasps on the laterals would have kept the denture in place but would have caused the teeth, especially the laterals, to weaken.

After studying the model carefully, I decided to try out a theory that I had had in mind for some time.

A casting was made covering the entire model surface, cutting out around the anteriors and molar. Around the buccal surface of the molar a casting of gold was soldered to the plate to make the gold surround the molar, fitting snugly to the buccal surface of the molar.

From the center of the denture toward the molar a strip of gold

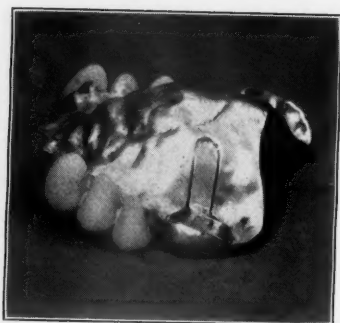


Fig. 2

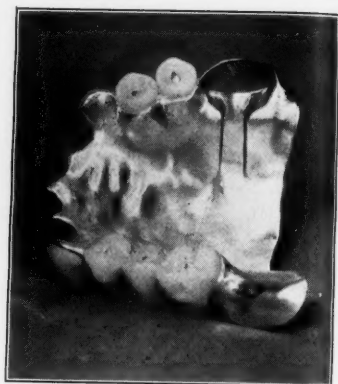


Fig. 3

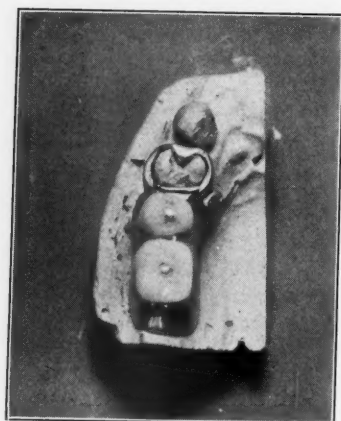


Fig. 4

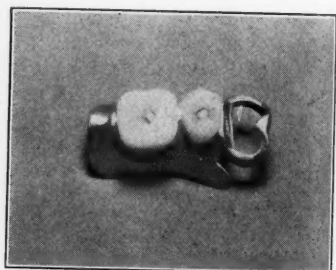


Fig. 5

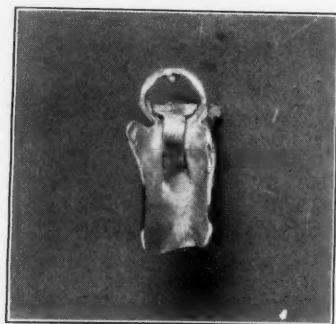


Fig. 6



about  $1\frac{1}{4}$  inches long was cut away. In this opening was soldered a piece of clasp metal with a rest to fit the palatal surface of the molar.

The soldering of clasp metal strips to the center of the denture gave a spring to the rest, causing the right side of the denture to remain in place.

This denture without teeth was delivered to the dentist, who tried it in place and was much impressed by the way the denture stayed up, snugly fitting the palatal surface of the mouth.

This type of clasp equalizes the pressure by having strips around the buccal surface of the molar. The attaching of clasp metal to the center of the plate causes strain to come past this point, thus forcing the denture up on the opposite side from the attachment.

Figures 1-3 show the finished denture.

The patient can easily tighten the attachment with his fingers by pressing down the clasp wire holding the rest.

This type of attachment seems to overcome the big failure of dentures with anchorage on only one side.

Figures 4-6 show a small restoration with the same type of retention applied.

2025 Broadway.

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## Important Announcement in the Journal of Dental Research

The following foreword in the last issue of the Journal of Dental Research, by the Editor, Prof. William J. Gies, will interest many readers of THE DENTAL DIGEST.

### PAPERS OF EXCEPTIONAL VALUE BY DR. J. LEON WILLIAMS

Each of the next two issues of this Journal will contain a paper that represents the advanced work and mature judgment of one of the pioneer investigators of the structure of dental enamel.

By remarkable success in his latest technical procedures, Dr. Williams has obtained photomicrographic illustrations that are veritable revelations of the physical constitution of dental enamel.

In appreciation of the fundamental import of Dr. Williams's findings, the Journal will reproduce about 125 of these magnificent illustrations, of which approximately 100 will be full page Photomicrographic views of sections of enamel *without reduction in size*, and showing all details perfectly, as Dr. Williams has observed and described them.

## The First Dentists in America

By H. H. Manchester, New York, N. Y.

Who was the first regular dentist in the American Colonies is a question that cannot be decided without further discoveries, but one where such discoveries are still possible. At present two dentists seem to be running a "dead heat" for the historical honor. These are John Baker of Boston and Robert Woofendale of Philadelphia.

The writer has seen the flat statement that Woofendale was the first, on the ground that either in 1766 or 1767 he arrived in New York from London and began practice there. He had been instructed by Thomas Berdmore, the dentist of George III, and was thus a pro-

**John Baker,**  
*Surgeon Dentist,*  
**B**EGS Leave to take this Method of informing the Public, That he shall leave this Place in Twenty Days at farthest—That those who are disposed to apply to him may not be disappointed.  
 He also begs leave to express his Gratitude for the Favours he has received while in *Boston*; and hopes that those who doubted of the Safety of his Art, from its Novelty in this Country, are now convinced of its Safety and Usefulness.  
 Until he leaves this Town he continues at Mr. *Joshua Brackett's* in School Street; where he will be ready to contribute to the utmost of his Power to serve the Publick in his Profession.  
 His Dentifrice, with proper Directions for preserving the Teeth & Gums, will be to be had at Mrs. *Luffi's*, near the Town House, after he has left the Town. N. B. Each Pot is sealed with his Coat of Arms, as in the Margin of the Directions, to prevent Fraud.

An announcement of John Baker, the first dentist of Boston, and perhaps of the Colonies, January 22, 1767.

fessional operator. Later he went to Philadelphia and practiced there only until 1768, when he returned to England. These grounds, however, are insufficient to give him the honor.

In Boston John Baker must have been practicing as early as 1766, for on January 22, 1767, he advertised that he was to leave town in twenty days. In this advertisement he "hopes that those who doubted the Safety of his Art from its novelty in this country are now con-

vinced." This certainly implies that he was the first dentist in Boston, and from the date he may have arrived in the country before Woofendale. Moreover, further discoveries in early colonial newspapers or handbills may settle when each came or even disclose some one prior to them both.

Baker's notice thanks his old customers and states that his dentifrice, sealed by his coat of arms, could still be purchased in Boston.

It must not be thought strange that Baker and Woofendale put notices in the papers. The dental art here was so unknown that they had to announce their arrival and business either through the newspapers or by handbills. It is this fact, by the way, that makes it quite possible that their first notices may yet be discovered. This

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## WHEREAS many Persons are fo

unfortunate as to lose their Fore-Teeth by Accident, and otherways, to their great Detriment, not only in Looks, but speaking both in Public and Private :—This is to inform all such, that they may have them re-placed with false Ones, that looks as well as the Natural, and answers the End of Speaking to all Intents, by **PAUL REVERE**, Goldsmith, near the Head of Dr. Clarke's Wharf, Boston.

\* \* All Persons who have had false Teeth fixt by Mr. John Baker, Surgeon-Dentist, and they have got loose (as they will in Time) may have them fastened by the above, who learnt the Method of fixing them from Mr. Baker.

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When Paul Revere, the famous patriot, was a dentist. An announcement of September 12, 1768.

custom remained in use for years. Dentists, often finding one city did not supply sufficient business, made trips to near-by towns and gave notice of their coming through print. How legitimate they were may be guessed more or less correctly by what they said.

There are several other interesting notices of John Baker. The year after he left Boston, we find our famous patriot, Paul Revere, advertising on September 19th that if any teeth inserted by Baker came loose, as they would in time, he would fix them. He likewise advertised to insert new teeth, clean the teeth and perform other dental service. Revere must have kept up this work for several years, for on July 20, 1770, he advertised that, having fixed hundreds of teeth, he believed he was as well able to do it as any dentist that came out

of England. He also cleaned teeth and would wait on ladies or gentlemen at their lodgings.

In 1769 Baker was in New York, where he advertised to fill with lead or gold and to make artificial teeth. Still later he was in Philadelphia, but his subsequent history is unknown.

Another early dentist of Boston was Hamilton, who advertised on August 14, 1769, that he had lately arrived from London and would set teeth at \$2.50 each.

That same year, in New York, Michel Poree advertised that he was a surgeon dentist and would fit natural or artificial teeth from one to a whole set. He would also draw troublesome stumps and would clean the teeth.



An 18th Century caricature of a dental office.

One of the next of the regular dentists in the Colonies was James Gardette, who was born in Paris in 1756. He became a surgeon in France and emigrated to America in 1778, landing at Plymouth. He started work as a surgeon dentist and did some dental work in the French Army when they were at Newport in 1781. In 1783 he was in New York, and the next year moved to Philadelphia, where he continued to practice for some forty-five years.

Along with the French Army came another dentist, whom the friendship between the two countries no doubt influenced to settle here. This was Joseph Le Maire, whose name was also spelled "Le Mayeur." He came with the French about 1781 and did dental work

**Doctor Le Mayeur, Dentist.**  
**L**ATELY from New-York, who transplants teeth,  
 has taken lodgings at Mr. Greenfield's, five  
 doors above the Conestogoe Waggon in Market Street.  
 Any person disposed to sell their Front Teeth, or  
 any of them, may call on Dr. le Mayeur, at his lodg-  
 ings, and receive two guineas for each tooth. \*3.

Dr. Le Mayeur, on coming to Philadelphia in 1784, offered to pay two guineas for front teeth.

in the French camp in Rhode Island that year. At that time also he taught Josiah Flagg, who is thought to have been the first dentist born in this country.

After the war Le Mayeur practiced for a time in New York and then moved to Philadelphia late in 1784. He made a specialty of transplanting teeth from one person to another, and when he first arrived in Philadelphia he offered two guineas each for front teeth to any disposed to sell them. In spite of the pain involved in parting with them a number must have done so, for Le Mayeur afterward advertised that he had transplanted one hundred and twenty-three in

**On TOOTH DRAWING:**  
*Addressed to a certain BARBER, in Arch-street.*  
**I**F the tooth complained of is a sound one and very firm in the socket, by all means *advise* the removal of it, and to make sure of the half dollar, tell the patient you only mean to try if it is loose, and instantly tear it out.  
 Always draw a sound tooth to cure a pain in the jaw, as the loss of a sound front tooth is attended with neither inconvenience nor deformity.  
 When you are determined to pull out a tooth, it is by no means necessary to separate the gum from the tooth, by an instrument called a scarificator, before you apply the lever.  
 Should the tooth be situated *behind* two other, it will be perfectly well done to drag it *forward*, through a smaller space than the body of the tooth, as there will be no risk of dislodging the foremost teeth, nor tearing away the gums and sockets of the adjacent.  
 When you fracture a jaw by attending to these rules, it will not be at all cruel or *barbarous*, to twist and jerk away with your fingers the unfortunate tooth, hanging by nothing more than splintered bone, gums and flesh of the lip.  
 The whole art of tooth drawing consists in a strong arm and a stout piece of rusty iron.  
 It is very prudent when you have broke away an *inch square* of the jawbone to conceal it in your handkerchief, and make a precipitate retreat from the sufferer's apartment, and when you are accused by one out of *numbers* of having done mischief, vindicate yourself with the proffered assistance of a most insignificant animal, by lies, insolence, and a pitiful attempt at wit.  
 Vine street. \$

A satirical notice to a barber, Philadelphia, 1784.

the previous six months. One Philadelphia lady had sixteen friends who had had it done. It was, nevertheless, two months before they could be eaten with.

At the time Le Mayeur came to Philadelphia a highly curious notice appeared in the advertising columns of the *Pennsylvania Journal* addressed to a certain barber on Arch Street and satirizing his work in ironical language. It was very possibly inserted by Le Mayeur to warn the public against his practices.

Another dentist of that date was Josiah Flagg. He was a major in the American army and a pupil of Le Mayeur while in winter quarters in Rhode Island in 1781. After the war he began practice in 1783, going from town to town to do the work required, as there was not enough to hold him in any one city.

One of his circulars read in part as follows:

"Dr. Flagg transplants teeth; cures ulcers and eases pain without drawing; fastens those that are loose; mends teeth with foil or gold to be as lasting and useful as sound teeth, and without pain in the operation; makes artificial teeth and secures them in an independent, lasting, and serviceable manner. . . Sells by wholesale and retail dentifrices, tinctures, chewsticks, masticks, teeth and gum brushes. . . ."

342 West 85th Street.

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## Resolutions on the Death of Dr. J. W. Birkland

*Whereas*, The late Dr. J. W. Birkland was taken from this life on November 7, 1924, after a three months' illness; and

*Whereas*, We loved him for his sterling qualities, modest and retiring disposition, his wonderful genius as a dentist and his devotion to his family and friends, be it therefore

*Resolved*, That the Chicago Dental Society in session assembled, express its appreciation of his many wonderful qualities, his unselfish devotion to the work of this Society, and be it further

*Resolved*, That the Secretary of the Chicago Dental Society be instructed to spread these Resolutions on the records of this Society, and send a copy to dental journals and to the family of the late Dr. J. W. Birkland.

(Signed) JAMES H. PROTHIERO, Chairman.  
FRANK G. CONKLIN,  
HUGO G. FISHER.

## A Dental Health Week

(Editor's Note.—There are many readers of The Dental Digest who have felt from time to time that they would like to "start something." Why not start a Dental Health Week in your city, county or state? This article is the first of a series setting forth how the Public Health forces of Pennsylvania are organizing various activities for a Dental Health Week throughout the State of Pennsylvania. Dr. C. J. Hollister is Chief of the Dental Division and is largely responsible for the movement.)

### SUGGESTIONS FOR CONDUCTING DENTAL HEALTH WEEK

Arrange (where possible) with ministers of all faiths to preach sermons on dental and general health or, at least, to announce the activities of Dental Health Week.

Enlist cooperation of local school authorities (public, parochial and private).

#### SCHOOL PROGRAM

1. Arrange talks about care of teeth to all school children by dentists, nurses or dental hygienists.

2. Conduct essay contests on *Care of the Teeth* among school children, prizes to be given by Parent-Teacher Associations, Rotary, Kiwanis, Lions, Quota, Civic Clubs or any other local organizations, judges to be superintendent or principal of schools, dentist and a member of club or organization awarding prize. Essay contest can be conducted in rural schools as well.

3. Care of teeth and general health posters to be made as part of drawing lesson in all schools.

#### COMMUNITY PROGRAM

1. Arrange for dental program for all community organizations, such as Rotary, Kiwanis, Lions, Quota, Civic Clubs, etc.

2. Where possible to have a community mass meeting with dental hygienist, nurse or teachers, train children in health playlets, tooth-brush drills, etc.

3. Have dentist give talk on care of baby teeth and description and value of six-year molar to mothers at all baby clinics.

4. Where it is possible to finance locally, have stickers (size 5 x 8) made to be placed on automobile windshields carrying the following slogan:

DENTAL HEALTH WEEK

WATCH YOUR TEETH

FEBRUARY 22-28, 1925



Also have larger cards with same slogan placed in show windows of local stores. Where there are trolleys, have this slogan at front and rear and inside of cars, if possible.

5. Have drug stores and all other places selling toilet articles make window display of toothbrushes and dentifrices.

6. Have motion picture houses and theatres make and show five slides. Suggested thoughts for slides are:

- (a) Dental Health Week  
Watch Your Teeth  
February 22-28, 1925.
- (b) Good Teeth for Good Health
- (c) False Teeth Are Like Crutches to Help a Lame Man Walk. Keep Your Own.
- (d) A Stitch in Time Saves Nine Applies to Teeth as Well as to Torn Garments.
- (e) Visit Your Dentist Twice a Year and Your Dental Troubles Will Be Little Ones.

7. Where a dental hygienist is available, arrange to have her demonstrate in show window of local department store, using portable equipment and working on school children. Put on two demonstrations a day, 11:30 A. M. to 1:30 P. M., 2:30 P. M. to 4:30 P. M. This has proved very effective.

8. Obtain all newspaper publicity possible, carrying notices of events of the week and prepared articles on *Teeth and Health*.

NOTE.—These suggestions are to be used in part or as a whole, added to or improved upon, according to personal opinion and local conditions. The object of this campaign is to give the public proper information on the importance and care of the mouth. The application of any plan or activity that will accomplish the same results should be used, whether mentioned in these suggestions or not.

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#### OUTLINE OF TALK TO BE GIVEN BEFORE SOCIAL SERVICE CLUBS, VIZ., ROTARY, KIWANIS, LIONS, CIVIC CLUBS, ETC.

- 1. Importance of good teeth to general health of the individual and community.
- 2. Results of medical inspection in Pennsylvania.
- 3. Prevention is the real solution of the dental defect problem.
- 4. Education is the logical method of prevention.
- 5. Some methods of educating children and the public.
  - (a) The dental hygienist in the schools.

- (b) Lectures and examinations by local dentists.
  - (c) Establishment of local dental clinics.
  - (d) The teaching of proper diet to build good teeth in future generations.
6. Reasons why Rotary, Kiwanis, Lions, Civic Clubs and other community service organizations should be interested in the correction of dental defects in the community.
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### SUGGESTED TEXT FOR A TALK TO BE GIVEN BEFORE SOCIAL SERVICE ORGANIZATIONS

Sir William Osler, several years ago, stated that more human suffering was caused by defective teeth than by alcohol, and he never minimized the sufferings caused by that drug. The Mayo Brothers, famous surgeons of Rochester, Minnesota, are quoted as having said that 80% of all of the diseases that the human body is heir to are directly traceable to mouth and teeth. Booker T. Washington, the colored educator, once said, "If I can teach the negro the gospel of the tooth-brush, I feel that I can make a man of him."

The general practitioner of medicine will concur in the statement that all general disease has malnutrition as a fundamental factor. The significance is that defective teeth and malnutrition are almost invariably a hand-in-hand proposition. Specialists in the treatment of tuberculosis constantly say that it is almost impossible to arrest or cure this disease if the mouth is not in good condition. The mouth is the "gateway" to the body, and the teeth perform the first step in digestion. If, due to lack of teeth or to the presence of abscessed or broken-down teeth, this first step is not properly accomplished, it is readily understood that the rest of the digestive processes are overburdened either by lack of thorough mastication or by contamination by the poisonous products of the diseased mouth.

Figures gathered as a result of medical inspection in Pennsylvania during the last several years have told us that 70% of the school children in the State have dental defects. This 70% of dental defects is more than all other physical defects combined, which include flat feet, bad eyes, ears, nose, throat, heart, lungs, etc. These figures bear out a statement made a long time ago that dental caries or tooth decay is the most prevalent disease known to mankind.

The facts just stated are not new and have resulted in the establishment of dental clinics in large numbers throughout the United States. Some of these clinics have been in existence for twelve or fifteen years, or long enough to be judged as to their efficiency, and those in position to know make this assertion: "While the dental clinic has been of great

service, it is entirely inadequate to meet the problem at hand." Preventive service rather than corrective is the real solution of the dental defect problem, and education is the logical method of prevention.

There are a number of methods that are practical to use in educating both children and the general public. From the experience in Bridgeport, Connecticut, where in a period of five years the number of cavities found in school children's mouths was reduced 50% by the use of a specially trained worker called a "dental hygienist" (they now employ twenty-six dental hygienists in the Bridgeport schools), and from the experience of about seventy-five local school dentists in Pennsylvania where the dental hygienist has been employed, this method seems to be the most practical. The dental hygienist is a young woman trained to clean teeth. She does not extract, nor does she fill. She does not even make a definite diagnosis. She simply cleans teeth, but she is more than a scrubber of teeth in that she teaches the child, both individually and in the classroom, the *how, why and when* of the toothbrush and, fundamentally, what to eat and how to eat it, also giving some instructions on principles of general hygiene. A dental hygienist having (1) the spirit of service to humanity and (2) vision to see her possibilities as a general health worker has a greater opportunity to improve general health conditions of a community than a member of any other class of social service in existence.

The dental hygienist has an approach to the child which is entirely different from any that other health and welfare workers have. First, she has the child alone, often for its first experience in a dental chair. In the hands of a tactful and careful hygienist the child has the surprise of a pleasant experience in the dental chair instead of one of suffering, as anticipated from intuition and hearsay. This pleasant surprise wins the child's confidence. The hygienist then can exert an influence over the child along dental and general hygiene lines, as well as in giving instruction as to proper diet.

The dental hygienist has proved herself to be not only a cleaner of teeth, but also a molder of good habits in children.

The Dental Hygiene Demonstration Unit of the Pennsylvania Department of Health some time ago was giving a demonstration in a town of about 5000 population. The first child presenting himself for a prophylaxis was one of the dirtiest urchins imaginable. He approached the dental hygienist in a rather fresh and insolent way, saying, "I want my teeth cleaned." The dental hygienist upon observing his general condition of uncleanness said in a tactful way, "I cannot work for you; you are too dirty," but she took the lad to a convenient washstand and began to talk to him about cleaning up. It wasn't long before the boy grabbed the nail brush and soap and tried to remove the dirt from underneath his finger nails. He shampooed his hair and

washed back of his ears. It was an unusual procedure, I assure you. He came back and sat down in her chair and she cleaned his teeth, talking to him all the while and trying to interest him in himself. His teacher came into the room during this operation to observe what was going on. When the boy was dismissed from the chair, he turned to the hygienist without being prompted and said, "Thank you." Without exaggeration that teacher's eyes became saucerlike. She turned to the director of the demonstration and said, "That kid has been in my room nine months and that is the first sign of courtesy I have ever seen him show!" This example proves that boys and girls will behave better if they have clean teeth.

Another method of educating the children especially is for local dentists to volunteer to give lectures and make examination of the teeth for the local school children. At the present time the two local dentists of Coudersport, Potter County, Pennsylvania, are working in just this way. Coudersport is too small to consider the employment of a specially trained worker for this service, so these dentists volunteered to do it. The plan they have adopted is as follows. They offered to give to the local school board one half-day each to the cleaning of children's teeth from the schools, the community nurse and principal to see that children were brought to their private offices for this purpose. In this manner they will clean the teeth of all of the children of (at least) the first three grades without compensation. In addition to this practical service they are giving talks on the care of the teeth in every classroom of the town schools.

Still another method of doing educational work along this line is by stimulation of the teachers to promote interest among the children under their charge in regular brushing of the teeth and the practice of other hygiene principles. An example of this is shown in the work of the Lions Club of McKeesport, where, during a six weeks' period, members of the Club after having been given proper instructions were assigned to the various school buildings of the city and spent, at least, one half-day a week in giving instructions in toothbrush drills and general hygiene to both teachers and pupils. In an inspection of 3500 school children of McKeesport made by a member of the State Health Department recently but four pairs of dirty hands were found. During his tour of inspection, as he left each room he was given a Chau-tauqua salute by the children and one hundred per cent of the handkerchiefs were clean, and the condition of the children's hair and clothing was excellent. The teachers interviewed were enthusiastic over the results of this campaign by the Lions Club and without exception made the statement that the deportment and application to studies were very much improved. As a result of the work of the Lions Club,

the school board of this city is now planning to put on a specially trained paid worker to carry on this service permanently.

There is another method of educating which is being used quite successfully, particularly in Virginia, and which applies to the rural districts. There the State Department of Health operates a number of corrective dental clinic units on a cooperative basis with the local rural school districts, these clinics charging a minimum fee, where possible, for all service rendered, and by this means they are carrying dental service to otherwise practically inaccessible localities. (If the local group before which this talk is given is interested, due to location, in the rural problem, further detailed information can be given by addressing the Dental Division, State Department of Health, Harrisburg, Pennsylvania.)

The fundamental principle involved in assuring to children of future generations good teeth and healthy bodies is in the teaching of proper diet. If we eat exactly what we should in the way we should, it would not be necessary to talk about the care of the teeth nor would we be much concerned over general disease. Animals do not have toothbrushes nor do they have toothache; and, again, living in their natural environment, animals do not suffer from general disease. They die a death of either violence or old age, and when they die of old age, they do not give out in any one part or function, but rather break down simultaneously all over just like the "One-Hoss Shay" of poetic fame. The modern human machine does not go that way, and it is usually the chewing apparatus that gives out first.

This club or organization (Kiwanis, Lions, Rotary, Civic, etc.) is organized and functions for the purpose of bettering civic conditions. It is our opinion that you can do no greater community service than lend your influence toward the establishment of a definite program which will tend to make for better teeth, especially among the children of the community. The boys and girls of today are the citizens of tomorrow and anything that you can do to make their opportunities greater and place them in a better physical condition to take up their obligations as citizens will be a fulfillment of the objective for which your Club is striving and that is making your community a better place to live in.



## Resolutions by Preventive Dentistry Section, First District Dental Society, New York\*

*Whereas*, The Section on Preventive Dentistry of the First District Dental Society, State of New York, was organized for the purpose of studying problems concerning the prevention of dental disease and for the dissemination of knowledge pertaining to preventive dentistry, and

*Whereas*, A broad interpretation of preventive dentistry includes within its scope the early discovery and treatment of dental caries and other dental abnormalities, and

*Whereas*, Advanced dentistry recognizes the importance of preserving the deciduous teeth throughout the deciduous period, and recognizes and insists upon the importance of the detection and filling of incipient caries in all teeth, and

*Whereas*, It is the common practice of some dentists to refuse to fill carious cavities in deciduous teeth upon the ground that "they are but temporary teeth and will be replaced by the permanent teeth" and to decline to fill small cavities in either deciduous or permanent teeth upon the ground that "they are not large enough to fill," and

*Whereas*, Such practices are not in keeping with modern teaching and practice and are obstacles to the progress of individual and organized efforts toward obtaining the objectives of the Preventive Dentistry movement, therefore, be it

*Resolved*, By the Section on Preventive Dentistry of the First District Dental Society, State of New York, that habitual failure properly to remove carious matter and properly to fill cavities in deciduous teeth solely on the ground that such teeth are but "temporary and will later be replaced with permanent teeth," and habitual failure properly to prepare and fill carious cavities in any teeth, on the ground that such cavities are too small to fill, constitute a transgression of the accepted principles of advanced dental teaching and practice and are therefore detrimental to the health and well-being of the public; and be it

*Resolved*, That such practices are unreservedly condemned; and be it

*Resolved*, That nothing in these resolutions is intended to restrict the freedom of action of the dentist in individual cases where illness or other causes would prevent the application of these principles of routine practice; and be it

*Resolved*, That all Dental Societies, Local, State and National Societies, as well as other unaffiliated professional Dental Associations, are asked to adopt similar resolutions.

\* Passed January 14, 1925.

## State Board of Registration and Examination in Dentistry of New Jersey

The State Board of Registration and Examination in Dentistry of New Jersey will hold its regular examinations at Trenton, N. J., commencing June 29, 1925, and continuing for five (5) days thereafter. License fee, \$25; re-examination fee, \$10.

Practical tests required: insertion of an approximal gold filling with the approximating tooth in position; compound approximal amalgam filling and a silicate filling (candidate must furnish his own patient); taking of impressions, bite, selection of teeth, articulation, trial plate (candidate must furnish his own patient); practical examination in mouth diagnosis.

Attention is directed to the following quotation from the dental law of New Jersey: "Applicant shall present to said board a certificate from the Commissioner of Education of this State, showing that before entering a dental college he or she had obtained an academic education consisting of a four-year course of study in an approved high school or the equivalent thereof."

In accordance with this law the secretary will issue application blanks only upon presentation of the required certificate from the Commissioner of Education, State House, Trenton, N. J.

Candidates are to be given the privilege of appearing at four examinations during a period of three years. Upon failure to be eligible for a license after four examinations they shall be required to take the entire examination over and upon further failure to secure a license after four more examinations during a period of three years, they shall be ineligible for further examination.

Application must be filed, complete, ten days before the date of the examinations.

Address all communications for further particulars to

John C. Forsyth, Secretary,

429 East State St., Trenton, N. J.

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## Stomatology at the New York Polyclinic Medical School

A Department of Stomatology has been established at the New York Polyclinic Medical School and Hospital, New York City. Anthony Bassler, M.D., F.A.C.P., Professor of Gastro-enterology, is head of the Department of Gastro-enterology, of which the section in stomatology is made a part. Professor Bassler is a charter member of the American Stomatological Association and a member of leading



medical societies and is associated with many hospitals in the City of New York.

Alfred J. Asgis, ScB., D.D.S., Chief of the Pyorrhea Clinic, Department of Stomatology, Midtown Hospital; Director of the New York Stomatological Clinics; Editor of the *Review of Clinical Stomatology*; Chairman of the Mouth Hygiene Committee, American Health Association; Secretary of the International Stomatological Federation (F. S. I.), has been appointed Clinical Professor of Stomatology.

The purpose of the section in stomatology is (1) to teach stomatology and its allied subjects, (2) to conduct clinics in stomatology and its allied branches, (3) to care for the hospital patients, and (4) to carry on research in stomatological problems.

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### Dr. Rollo Knapp

It is something to follow a profession for fifty years and be highly honored by its members. That honor was bestowed the other evening on Dr. J. Rollo Knapp, who for half a century has practiced dentistry in New Orleans.

The years have been kind to Dr. Knapp. He was born with a happy outlook on life and his optimism has continued from birth. No one who meets him now would ever accuse him of being as old as the Board of Health records prove.

He has been one of the most advanced of the members of his profession. We believe that he was first here to catch the spirit of modernity and to make dentistry as painless as it can be made. The fact that a Sarrizin presided over the banquet tendered him on the golden anniversary of his entry into the profession is as fine a compliment as could be paid him.

He has been showered with many honors, professionally and otherwise. He has been a good citizen. Generally we have found him on the right side of propositions which make for the good of the community.

He is old in years but young in spirit. May he, in the language of our old friend Rip, live long and prosper.

—*New Orleans Times-Picayune.*



## Every Dentist Should Read this Letter

Many members of the dental and medical professions during the past few years, after direct investigations, have concurred in the opinion that numerous maladies of the body can be caused by diseased conditions of the teeth and gums. Tonsillitis, eye troubles, insomnia, anemia, rheumatism and intestinal disorders are some of the conditions traced to this source.

The recent death of England's greatest medical authority, Sir James Mackenzie, has caused this theory to assume a very important aspect. A letter written by Sir James shortly before his death to one of his co-workers, and now published in the London Times, is termed the most remarkable document that the medical world has been called upon to consider in many years. The Lancet says that "the death of Mackenzie removes from the ranks of medicine one of its greatest figures. He was one of the small group of men whose individual labors have revolutionized fundamental medical views." The letter, cabled to the N. Y. Times, is as follows:

"When outlining the first result of researches made at our institute, I saw there was undoubtedly a great fundamental principle, which, if discovered, would do for medicine what the atomic theory has done for chemistry. I scarcely expected to discover the principle, but hoped to lay the basis of methods that would in the course of time achieve this success. I am now, however, of the opinion my co-workers and myself succeeded and that it only wants time and experience to start a revolution in every department of medicine.

"Briefly the principle may be described as follows: We recognized early that functioning cells of an organ of the body are controlled and regulated by impulses generated by cells of other organs and conducted to and from by structures specially evolved for the purpose. In the production of any manifestation of activity, be it the symptom of a disease, or an experimental reaction, the source of the impulses giving rise to the activity is to be found in structures other than those which actually exhibit the symptom or reaction. Thus in our theory all symptoms, apart from those arising as a consequence of structural changes, are due to the disturbance of some element intervening between cells of the body which give rise to the impulse and those which receive it and carry it into effect.

"We proceeded next to analyze elements of this reflex arc, that is to say, the chain of structures connecting cells which give rise to impulses with those which execute them. We were thus led to

consideration in the first instance of the cell impulse itself. How is it generated, how is it conducted and how does it produce its effects? We found that the living cell is never at rest, but always either discharging energy, i. e., performing its functions, or renewing it. Discharges are momentary, whereas the time of renewal can be varied. This cell activity can be altered only in two ways—by increase or by decrease in the period occupied by the process of renewing energy. Heat and cold act respectively in this manner. Heat increases and cold retards the rate of renewal of cellular energy. When a living cell discharges its energy, i. e., when it performs its appropriate function, it discharges also at the same moment an impulse or influence which affects the neighboring cells and either hastens or delays the process of renewal of energy in them. To these effects the names stimulation and inhibition respectively apply.

"But we found, in addition, that the cell impulse exercises another influence, namely, control. In certain cells this power of control is much more highly developed than in others, examples of highly developed control being the group of cells in the heart, known as 'the pacemaker,' because of their influence on the rhythm of that organ. Certain nerve cells possess the same power. It is by the influence of these structures that organs of the body are caused to work harmoniously together. Symptoms, therefore, are due to agents which either increase or decrease the activity of the cells or which interfere with the normal control exercised by certain cells over others." Mackenzie said in conclusion:

"I trust to be able to put forward such a mass of evidence as will demonstrate, if not the truth of our principles, at least that there are some such principles of which the profession is today ignorant. I have discussed the matter with learned members of different branches and few of them will accept our conclusions. I should, indeed, be surprised if they did, for history tells us that the introduction of all such revolutionary principles is not only not accepted by authorities, but is strenuously opposed by them."



## February Meeting

### SECOND DISTRICT DENTAL SOCIETY OF NEW YORK

(This report is neither official nor complete. It represents the impressions made by the speaker on one of the audience.)

At the fifth regular meeting of the Second District Dental Society, New York, held in Brooklyn on February 9th, Dr. Norris G. Leonard of Baltimore, Maryland, read a paper entitled *Observations Concerning Partial Extirpation of Vital Tooth Pulps*.

After saying a few words concerning the history of the development of pressure anesthesia, Dr. Leonard reported some clinical facts from his own experience with regard to extirpation of vital pulp, particularly in deciduous teeth, and gave his technic in the handling of his cases. He hopes to stimulate work along this line with a view to developing better methods, particularly in caring for children's teeth, with which, as an orthodontist, he is especially concerned.

"If the advent of devitalizing agents and that of local anesthetics should have exchanged places chronologically in dental therapy, is it not reasonable to believe that by now we should have developed a surgical technic that would care more simply and safely for the cases involving treatment of vital teeth with pulp lesions?" asked Dr. Leonard.

As far back as 1896 the essayist became so impressed with the subject of pressure anesthesia as presented by Dr. U. D. Billmeyer of Chattanooga, Tenn., that the procedure was employed exclusively by him thereafter, as against the use of devitalizing agents. Early in the use of this method his satisfaction with pressure anesthesia applied to permanent teeth soon led him to experiment with it on deciduous teeth. Confronted then with the problem of root filling in the latter class, root filling seemed impractical to him from every standpoint. Extirpation of only the coronal portion of the vital deciduous pulp was then begun as an experiment, dressing the remaining stumps of the pulp with an aseptic and mildly disinfectant paste, and sealing the cavity with a permanent filling at the same sitting.

This method proved satisfactory from the beginning and was used with only slight modifications of technic during a period of approximately twenty years of general family practice, and Dr. Leonard's records show, as stated by him, several hundreds of cases to which it was applied, no effort being made to select only favorable cases. All definitely vital and exposed deciduous pulps were treated in this way with remarkably consistent results. There was no pain or swelling, no soreness or other evidences of abscess, and the shedding in all cases

noted was apparently in a perfectly physiologic manner. Every vestige of the roots was absorbed, as well as much of the dentine in the coronal portion. Less than one per cent of the cases were failures.

Dr. Leonard said that his assumption was that the abundant vascularity due to large apical foramina and, usually, partly absorbed root apices would compensate for the traumatic injury, favor the repair of the pulp stumps and cause their vitality to be retained. This latter, he feels, is the question to be determined, and this perhaps shall be the measure of the value of the operation. His own interpretation of the evidence, which he admitted is incomplete, is entirely favorable to him. Roentgenray examinations have proved negative, and the difficulties of adducing conclusive evidence are obvious, he stated.

"I have no evidence to present that is definite or at least conclusive as to the pulp stumps remaining permanently vital," said Dr. Leonard, adding, "or as to just what the ultimate response will be to the changed environment." The one case exhibited in which the radiograph shows incomplete apices at the time of operation, and fifteen months later shows practically completed root ends, he believed was pretty definite evidence that the function has not been seriously disturbed. And he assumed that since pathology of the pulp is the same as pathology of other connective tissue, its response to irritation and its reparative processes are likewise analogous. To expect reparative processes about clean lesions of the pulp that are also free from too great a mechanical irritation he believed to be entirely consistent with the best clinical observation, as well as histologic deduction.

In conclusion the essayist said: "The surgical removal of the infected portion of the pulp, which is excised at a point safely distant from the infected areas of carious dentine, would seem, from a practical standpoint, when the wound has been suitably protected with a non-irritating permanent dressing, to give much more favorable chances for repair and persistent vitality, aside from the factor of the greatly lessened amount of pulp tissue to be supported by the same vascularity. It is hoped, only, in presenting these observations to stimulate serious investigation into what would seem to me to be a very promising though much neglected field of professional endeavor."

The discussion, while generally opposed to the contentions of the essayist, failed to bring out anything new.



## Clinic and Dinner of the St. Louis Study Club of Dentistry

At two o'clock on Saturday, March 21, 1925, at the Coronado Hotel, Spring and Lindell Streets, the St. Louis Study Club of Chemistry will hold its seventh annual clinic, to which every ethical dentist is invited.

This institution, organized in January, 1919, is maintained for the purpose of teaching practicing dentists the latest and most modern developments in the science of dentistry. At the conclusion of each term a clinic is held in order to show to the profession the results achieved in each of the subjects taught.

Inasmuch as neither the officers nor instructors receive compensation for their services, it is possible to conduct these classes without cost to the students.

The one hundred twenty-six students who were enrolled in the 1924-1925 term will participate in group clinics in the following subjects:

- Drawing
- Dental Roentgenology
- Fixed Bridgework
- Porcelain Technic
- Cavity Preparation and Casting Technic
- Full Dentures
- Root Canal Technic
- Oral Diagnosis and Diseases of the Mouth
- Conduction and Local Anesthesia
- Operative Dentistry.

Following the clinic, a dinner, at which the members of the faculty will be the guests of honor, will be given. Ethical dentists are cordially invited to attend this function.

Bulletins, descriptive of the Study Club, may be had by addressing Dr. F. C. Rodgers, 309 Wall Building, St. Louis, Mo.

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## The New Jersey State Dental Society

The fifty-fifth annual meeting of the New Jersey State Dental Society will be held at Hotel Robert Treat, Newark, N. J., Wednesday, Thursday, Friday, Saturday, April 8, 9, 10, 11, 1925.

The literary program includes papers by E. C. Kirk, D.D.S., Sc.D., LL.D., Emeritus Professor of Dental Pathology and Therapen-

tics, The Thomas W. Evans Museum and Dental Institute, School of Dentistry, University of Pennsylvania, on *The Vital Question*; by Boyd S. Gardner, D.D.S., Dental Surgeon at the Mayo Clinic, Rochester, Minn., on *Dentistry in Group Medicine; Significance of Infected Teeth and Their Surgical Treatment*; by George C. Fahy, D.D.S., Oral Surgeon at St. Raphael's Hospital, New Haven, Conn., on *The Inferior Third Molar as a Distinct Entity*; by Clarence O. Simpson, D.D.S., M.D., F.A.C.D., St. Louis, Mo., on *Radiodontic Interpretation and Diagnosis* (illustrated).

Table and Chair Clinics will be presented by Theodore Blum, M.D., D.D.S., New York, on *Local Anesthesia*; Chas. A. Large, D.D.S., New York, on *Various Forms of Removable Crowns and Bridgework*; H. A. Maves, D.D.S., Minneapolis, Minn., on *Cast Gold Inlays and Bridges*; James S. Miller, D.D.S., Trenton, N. J., on *Balanced Occlusion in Full Dentures*; Arthur J. Norman, D.D.S., Detroit, Mich., on *A Technique for Use of Porcelain Gum Enamel in Fixed and Removable Bridgework and Partial Dentures*; Clarence O. Simpson, M.D., D.D.S., St. Louis, Mo., on *Oral Radiography and Diagnosis*; Leo Stern, D.D.S., New York, on *Local Anesthesia*; Frank Wadsworth, D.D.S., Los Angeles, Cal., on *Wadsworth Full Denture Technique*; Geo. Winter, D.D.S., St. Louis, Mo., on *Exodontia*; the Dental Clinic Club of Philadelphia, as follows: Frank Fox, D.D.S., Hugh McWilliams, D.D.S., on *Partial Denture Design*; M. M. DeVan, D.D.S., Benj. Benedict, D.D.S., on *Hall Articulator and Impression Technique* and Neil's *Lower Impression*; James I. Woolverton, D.D.S., Lyman Mesimer, D.D.S., on *Tench-Clapp System and Impressions and Gysi Articulator*; W. J. Robinson, D.D.S., and A. Kassab, D.D.S., on *Porcelain Abutments and Bridgework and Jacket Crowns*; Albert Mulford, D.D.S., on *Roach System of Removable Bridgework*.

To secure accommodations, make hotel reservations early.

Dr. F. K. Heazelton, Sec'y, 223 East Hanover St., Trenton, N. J.

Dr. John S. Owens,  
Chairman of Publicity Committee.





# DENTAL LAWS

## Summary of Dental License Requirements Throughout the World

By Alphonso Irwin, D.D.S., Camden, N. J.

### NEW MEXICO, U. S. A.

The Board of Dental Examiners consist of: President, Charles A. Eller, Albuquerque; Vice-President, Thos. J. Pearson, Roswell; Secretary-Treasurer, C. C. Clark, Socorro; C. M. Stanfill, Tucumcari; John J. Clarke, Artesia, New Mexico.

The Dental Laws of New Mexico are dated February 23, 1893, March 9, 1905, March 21, 1907, 1915, 1919. The English language, dental supervision, registration and examination are required.

*Rules:* New Mexico State Board Dental Examiners; information and rules governing Examinations for license to practise dentistry in the state of New Mexico.

1. All persons desiring to practise dentistry in the State of New Mexico must first apply to the State Board of Dental Examiners for an examination.

2. Applicants are to present to the Secretary of the Board, at least ten days before date for examination, their written application on a form furnished by the Board and said application must be accompanied by the fee of \$25.00.

3. Application must be sworn to before a Notary Public and accompanied by satisfactory evidence that the applicant is a graduate of a reputable dental school and is of good moral character, and a recent photograph (unmounted) of applicant.

4. As a safeguard to the public health a medical examination by two reputable physicians will be required of applicants where Board has reason to believe chronic infectious or contagious disease exists.

5. Examination shall be on such subjects as taught in Class A and Class B dental schools and shall be written and practical, both being graded equally, and no license will be granted to an applicant whose general average is below 75 per cent.

6. Applicant shall furnish dental engine and all necessary instru-

ments and material and patient to operate on; the Board will furnish chairs and laboratory tables.

7. The requirements for practical operations will be decided by the Board at the time of examination. Written examination shall be on paper furnished by the Board and written in the English language.

8. Applicants should bring models mounted on articulator for full upper and lower dentures, with full set of teeth for same. Two articulated models for use in making crowns, and extracted teeth to mount for crowning or cavity preparation.

9. Personal appearance, condition of instruments and equipment, writing and spelling will be considered by the Board. After two-thirds of the applicants are finished with a subject, other applicants shall have not more than thirty minutes to turn in their papers.

10. At present *Reciprocity* has not been arranged with any other states, and no permits or temporary licenses are issued. A fee of ten dollars will be collected for each license issued.

Annual renewal of the license must be made by June 1st with the Secretary of the Board of Dental Examiners, under penalty of suspension of the license; fee for renewal of license three dollars.

11. At present time *Reciprocity* has not been arranged with any other Board, but the New Mexico Board has power to do so. Clarence C. Clarke, Sec'y-Treas., Socorro, New Mexico.

Verified Sept. 29, 1924.

## NEW SOUTH WALES

### ANALYSIS OF DENTAL LICENSE REQUIREMENTS

1. Name of Commonwealth; 2. Date of Last Act; 3. Language; 4. Supervision; 5. Requirements; 6. Pre-dental; 7. Professional; 8. Hospital; 9. Clinical; 10. Degrees; 11. Theoretical or Written; 12. Practical; 13. Fees; 14. Time; 15. Place; 16. Passing Average; 17. License; 18. Registration; 19. Re-registration; 20. Re-registration fees; 21. Reciprocity; 22. Reciprocity fees; 23. Special; 24. Remarks; 25. Secretary's Name; 26. Secretary's Address; 27. Name of Dental School or University; 28. Name of Dean, President, Rector or Registrar and address; 29. Remarks; 30. Date of Revision of law or Amendment.

*New South Wales, Australia, Sept. 28, 1917.* The English language, Medico-Dental supervision. The Examining Board consists of two physicians to four dentists. License regulations and requirements; 1912 Act, Sec. 10—(a) a recognized certificate to prove he is of good character, or (b) 21 years old; 4 years acquirement of professional knowledge in dentistry; passed an examination before the

Board of Dental Examiners, according to the regulations, or (c) 21 years old; 2 years pupillage or apprenticeship under a registered dental practitioner, 6 months prior to Nov., 1900; or (d) has obtained a diploma or degree in dentistry from a University in Australia. Under "Registration of Dentists" we quote: The 1917 Acts add, Sec. 17. The following are the qualifications which will be recognized by the Board:

The license or diploma of any legally qualified Dental Board or other body which permits its holder to practise dentistry in the state or country in which it was obtained, and which has been granted after—(a) Passing an examination in general education equivalent to the standard of the entrance examination, dental curriculum, of the University of Sydney; (b) Four years' course of study of dentistry subsequent to the passing of the examination in general education as aforesaid; (c) Provided always that persons holding recognized certificates from countries or states which do not grant the right to practise dentistry to persons who are registered in conformity with Act 54, 1916, Section 7, shall not be registered without first passing an examination of the Dental Board of New South Wales in the following subjects, viz: Metallurgy (practical) as applied to dentistry only; Mechanical dentistry (practical and theoretical); *Materia Medica* and Therapeutics, as applied to Dentistry; Pathology and Bacteriology; Operative Dentistry (practical and theoretical); Special Dental Surgery and Orthodontia; and shall furnish proof of having dissected a limb, also head and neck. All the foregoing subjects shall be taken at one examination.

Fee for this examination is £10 10s. A candidate who fails in not more than two subjects shall be entitled to a deferred examination on payment of a fee of £5 5s.

18. (1) A candidate, under Section 10, Subsection (b) of the Dentists Act 26, 1912, for registration as a dentist shall produce satisfactory evidence to the Board: (a) That he has attained the age of 21 years; (b) That he is of good character; (c) That for four years he has been engaged in the acquirement of professional knowledge in dentistry; (d) That he has passed the examination prescribed by the next following subsection of this regulation.

(2) The subjects of the said prescribed examination shall be as follows: (a) English, Mathematics (Arithmetic, Algebra, Euclid), Latin and one of the following optional subjects, viz: Chemistry, Physics or Mechanics, or furnish proof of having passed satisfactory examination in these subjects; (b) Anatomy, Physiology, Dental Metallurgy, and furnish proof of having dissected a limb and head and neck, or furnish proof of having passed the foregoing subjects; (c) Mechanical Dentistry (Theoretical and Practical); Operative Den-

tistry (Theoretical and Practical); Dental Pathology and Bacteriology; Dental Materia Medica and Therapeutics; Dental Surgery; Orthodontia. The foregoing subjects may be taken in three parts as indicated, or at one examination.

(3) The fees for each of the examinations, if taken separately shall be £5 5s.

(4) A candidate taking only part (c), and who fails in not more than two subjects, may be allowed a deferred examination in such subjects on payment of £3 3s.

(5) A candidate taking more than one part at one examination, and who fails in not more than three subjects, may be allowed a deferred examination in such subjects on payment of a fee of £3 3s.

19. The following rules shall apply to examinations under these foregoing regulations: (a) The examinations shall take place each year on dates fixed by the Board; (b) No candidate shall be allowed to sit for an examination without first having paid all fees; (c) If a candidate shall sit for and fail to pass any examination, his fee shall not be refunded; (d) A pass at the rate of 50 per cent shall be required in each subject; (e) Every candidate shall, fourteen clear days previous to the first day fixed for the examination, give the Registrar written notice of his intention to present himself at such examination; (f) The examiners' decision as to the result of the examination shall be final.

20. The Board may from time to time appoint suitable persons as examiners to examine under the direct supervision of the Board and its Officers applicants for registration.

21. The Board may enter in the Register any additional degrees, diplomas, or titles acquired by a dentist, provided in the case of dental degrees, diplomas, or titles the examination passed in order to obtain the same necessitates a higher degree of knowledge than is required to entitle registration under the Act. The Board may, after calling upon the holder thereof to show cause, remove any such degrees, diplomas, or titles from the Register.

22. In every application for registration as a dentist, under Sections 10 and 11 of the Dentists Acts, 26, 1912, and Section 5, Subsections 1, 2, 3 and 4 of Act 15, 1916, the Board may demand proof in the following way in support of the requirements of the said sections, and in order to satisfy the Board as to the bona fides of such application, viz: (a) Statuary declarations from a magistrate, and at least three responsible citizens of undoubted standing; (b) Such other evidence by sworn affidavit or evidence on oath as the Board may deem necessary in support of the application, or of any statement made by the applicant, or of any facts the Board may deem necessary to be established in connection with the application.

23. The examination provided by Sections 10 (b) of Act 26, 1912, and 5 of Act 15, 1916, Subsections 1, 2 and 4, shall be held semi-annually for three years from commencement of Act 15, 1916, on dates to be fixed by the Board. The examination shall consist of an oral and a practical examination in surgical and mechanical dentistry and an oral examination in *Materia Medica* (dental). A pass at the rate of 50 per cent in each subject shall be required. Fee for each examination shall be £5 5s.

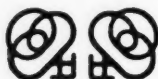
24. Persons applying under the provisions of Section 10 (b) of Act 26, 1912, and Section 5, Subsection 4 of Act 15, 1916, must produce articles or indentures of apprenticeship duly signed and discharged by their masters.

25. Persons who are accepted in accordance with the provisions of Section 10 (b) of Act 26, 1912, and Section 5, Subsection (3) of Act 15, 1916, shall pass a written and oral and practical examination in surgical and mechanical dentistry and a written examination in *Materia Medica* (dental).

26. An applicant for registration must submit with his application an unmounted photograph of himself satisfactory to the Board, duly signed with his usual signature across the lower right hand corner, for the purpose of identification.

27. (a) The registration certificate of the Board is set out in Schedule to these Regulations, and will be the only document granted to successful candidates for registration. Every dentist registered by examination or otherwise must hold the registration certificate of the Board; (b) During the month of October in each year, every registered dentist shall file with the Registrar a memorandum under his hand, setting out his address. Where the address thus furnished differs from that already furnished, a fee of 5s. must be paid for the alteration, and if any registered dentist fails to file such memorandum, or to pay the prescribed fee, he shall be liable to a penalty not exceeding £2, to be recovered in a summary way before two justices.

Revised May 1, 1923.



# DENTAL ECONOMICS

## The New Era

Walter S. Kyes, D.D.S., San Diego, Cal.

I walk down to my office every morning; the doctor says it's good for me—just what I need—although *he* invariably rides. On the way down town I pass a good many buildings under construction. We are enjoying a building boom of no small proportions, and those to whom we have been accustomed to refer as “laboring” men are, it would seem, very busy and prosperous. These men ride to and from their labors in their own cars, leaving them all day long standing out in sun and rain. Sometimes I count from six to fifteen cars along the curb. One of these men whom I have known for some time was complaining to me about the cost of operating his car. It is a big six-cylinder and when I suggested that he buy a smaller one in order to reduce his expenses he said, “Oh, doctor, when you get used to the feel of a big, powerful car you can never feel just right riding in a smaller one; it's the sensation you get when you *step on her!*”

This attitude of mind, which is so widespread at present, is indicative of the New Era in which we live and, strange as it may seem, so many of us are yet unconscious of it. Far be it from me to envy the good fortune of my fellow man, but I am quite certain that good fortune should not be confused with extravagance, and to me the situation in which my friend finds himself offers no delusions.

Among men who labor—and, despite all, we are all laborers whether working on a scaffold, at the dental chair or in an office disbursing accumulated millions—there has been a tremendous shifting of positions. Time was when the professional man, the bank cashier and men employed along such lines of endeavor were the envy of the man in overalls, but it would seem that conditions have changed until positions, considered in terms of income, are reversed.

Among my acquaintances I number a plasterer. He is a pretty good sort of man, who is worth knowing for his viewpoint alone. He is illiterate, and almost always hard up. He is a remarkably happy man, unreasonably so at times. For eight hours' work he receives more money than does a neighbor who is assistant cashier of one of our

largest banks, and very much more than the net average income of the dentists in the country. I in nowise begrudge him it, but he is an interesting study. He has perhaps a hundred dollars invested in tools; he never saw the inside of a higher institution of learning—except perhaps when it was being plastered! Aches and pains, that is, those of other people, never disturb his nights or his days. He has no bad accounts to regret, and no overhead. He begins work at 8 A. M., and if he arrives too early on the job it is his custom to build a fire, if need be, on the sunny side of the building and joke and smoke with his companions until eight o'clock comes round. He has a great golf arm, but it is of no expense to him whatsoever—he uses it for other purposes. I never see him in the evening when I go home because he has already gone an hour or more before me. This friend of mine has never known the loss of time coincident with procuring an ordinary education or the cost of special training. Society does not demand very much of him in the way of accomplishment, culture, association or dress. Excepting for tax-paying time and visits from the walking boss he is left pretty much to his own devices. Seemingly he is pretty well satisfied with his lot. When I inquire if he expects that the present wage scale will continue, he replies, "You bet, Doc, we're going to *make* it stick!" Of course it is presumed that he will not object to a raise at any time. He now receives fifteen dollars per day regularly and, when engaged in some special work, he often "pulls down" as much as twenty-two dollars per day.

To present another viewpoint, I will cite the experience of a friend. He is a man of culture. He gave up a position as an educator on account of his health. Now he is engaged in the egg-production business, which is a Farm Bureau name for the chicken business. In the course of events he found it necessary to build an addition to his house. He paid his plasterer at the rate of 60 dozen eggs per day and his carpenter at the rate of 40 dozen eggs per day, 720 and 440 eggs, respectively. After settling his bills he said that, compared with certain other lines of activity and all things considered, the egg-production business needed rejuvenating because it didn't pay. He is disillusioned!

With so many such instances of this sort of thing coming to my mind, I fell to thinking about the matter of education plus special training, wondering whether or not it pays, of course using the term in its broader sense. I discussed it with an acquaintance who is also an ex-school man. He is now selling blotters and calendars and says the work is paying him well. Putting the question bluntly to him, I asked him if he really thought that an education, all things considered, was a good investment. He threw up his hands in a rather shocked manner, exclaiming, "Why Doctor, that is ridiculous, coming from a man of your sort! Of course education pays! Don't you know that brains, cultivated gray matter, always win out?"



"Hold on," said I. "You are getting too enthusiastic about brains, putting too much of a premium on them. Now, for instance, in the matter of Russia, brains suffered and died and in many instances were tossed into a ditch, not even afforded a decent burial. In that unhappy land brains and culture succumbed to—what shall I say?—instinctive cunning. Following which you will recall there was built up just as hideous and absolute and as confiscatory an autocracy as the world has ever known, and in and through it all seemed to predominate the primeval instinct of a subtle craftiness and an age-old hatred—and it triumphed!"

Our discussion was too long to record here, but we finally agreed that in our onward march of progress—if such it is—education must in nowise be overdone or ignorance ignored; that there must be worked out some plan that will draw the classes closer together; and that an education must not necessarily set a man apart from his fellow man, but that it should promote harmony instead of discord, fellowship instead of jealousy and hatred.

Another peculiarity of this New Era is that families are much smaller among cultured people, who offer the excuse that the cost of living makes this necessary. One cannot resist asking the question whether it is due to the cost of living or to the *manner* in which we live. Curious, is it not, that with all our special training and our methods of money-making, as compared to the skill and the methods of our fathers, how we waver before the prospect of assuming added paternal responsibility?

What has this New Era done to us or for us? Has it simplified life or added to its complexities? Is there any less toil or suffering, or any more love or happiness, or *is there just more pleasure*? If we are taking our pay from life in pleasure, is it equally distributed? Do the plasterer, the carpenter, the dentist, the physician share it equally? Is the pleasure that we are getting out of life worth the price we pay, and just where will it lead? If this New Era is diverting us from the pursuit of happiness to the pursuit of pleasure, what can and will happen to turn us back, putting us on an equal footing so that we may discern and share alike in the worth-while values of life?

It is not difficult to ask questions, to point out evils or to suggest reforms. However, if we of this generation do not meet this New Era wholeheartedly, its perplexities will only increase and it will become more complicated for those on whom will fall the problem of its analysis and solution. But no matter how largely we contribute to the solution of the problems that our civilization is creating, our contribution must be founded on justice to all.

812 Watts Building.

## Comparison of Possible Earnings of a Dental Student and a Laborer

By V. L. Lee, D.D.S., Chicago, Ill.

COMPARISON DURING FOUR YEARS OF HIGH SCHOOL, ONE YEAR OF  
COLLEGE, AND FOUR YEARS OF DENTAL SCHOOL TRAINING  
WITH THE EARNINGS OF A LABORER DURING THE  
SAME PERIOD OF TIME

### Four Years High School, or at the Age of 14 to 18

DENTAL STUDENT			LABORER		
<i>Possible Earnings</i>	Dr.	Cr.	<i>Earnings</i>	Dr.	Cr.
1st Year, 10 weeks'					
vacation @ \$9.....		\$90	50 weeks @ \$9.....		\$450
2nd Year, 10 weeks'					
vacation @ \$12.....		120	50 weeks @ 13.....		650
3rd Year, 10 weeks'					
vacation @ \$15.....		150	50 weeks @ 18.....		900
4th Year, 10 weeks'					
vacation @ \$18.....		180	50 weeks @ 26.....		1,300
<i>Expenses for 4 Years</i>					
Clothing for period above					
cost of that of la-					
borer .....	\$100				
<i>Total for 4-year period..</i>	\$100	\$540			
<i>Credit Balance .....</i>		440	<i>Credit Balance .....</i>		\$3,300
<i>Cost of education during this period =</i>					
<i>\$2,860, or \$3,300 — \$440.</i>					

### One Year College, or at the Age of 19

DENTAL STUDENT			LABORER		
<i>1 Year—Possible Earnings</i>	Dr.	Cr.	<i>Earnings</i>	Dr.	Cr.
14 weeks' vacation @ \$25. ....		\$350	50 weeks @ \$33.....		\$1,650
<i>Expenses</i>					
Books and tuition.....	\$150				
Board and room, 36					
weeks .....		504			
Clothing .....	200				
<i>Total for 1 year.....</i>	\$854	\$350	<i>Total for 1 year.....</i>		\$1,650
<i>Balance .....</i>		\$504			
<i>Cost of education during this period =</i>					
<i>\$2,154, or \$1,650 + \$504.</i>					

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 Four Years Dental School, or at the Age of 20 to 24
 

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DENTAL STUDENT			LABORER		
<i>Possible Earnings</i>			<i>Earnings</i>		
	Dr.	Cr.		Dr.	Cr.
1st Year, 14 weeks'					
vacation @ \$25.....		\$350	50 weeks @ \$42.....		\$2,100
2nd Year, 14 weeks'					
vacation @ \$25.....		350	50 weeks @ 52.....		2,600
3rd Year, 14 weeks'					
vacation @ \$30.....		420	50 weeks @ 63.....		3,150
4th Year, 14 weeks'					
vacation @ \$30.....		420	50 weeks @ 75.....		3,750
<i>Expenses for 4 Years</i>					
Tuition and books @ \$320	\$1,280				
Board and room, 36					
weeks, per year.....	2,016				
Clothing and fraternity					
dues, @ \$250.....	1,000				
<i>Total for 4-year period..</i>	<i>\$4,296</i>	<i>\$1,540</i>	<i>Total for 4 years.....</i>		<i>\$11,600</i>
<i>Balance .....</i>	<i>2,756</i>				
<i>Cost of education during this period =</i>					
<i>\$14,356, or \$11,600 + \$2,756.</i>					

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 Total Cost of Education of Dental Student
 

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1st period (4 years).....	\$2,860
2nd period (1 year).....	2,154
3rd period (4 years).....	14,356
<i>Total for 9 years.....</i>	<i>\$19,370</i>
Cost of furnishing office.....	2,000
	<i>\$21,370</i>

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 After Nine Years of Training
 

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DENTIST			LABORER	
<i>Average per hour</i>			<i>Average per week</i>	
	Dr.	Cr.		Cr.
2½ hours for gold crown .....	\$10.00		Plumbers .....	\$78 to \$108
Material, \$1.50; Overhead,			Carpenters .....	66 to 90
\$5 .....	\$6.50		Illinois Central diggers..	48 to 73
Balance for 2½ hours.. .....		\$3.50	Plasterers .....	66 to 100
			Steam Fitters .....	78 to 108
			Bricklayers .....	78 to 108
			Average .....	\$69 to \$98
Average per hour.....	\$1.40		Average per hour (44	
			hours per week).....	\$1.57 to \$2.23

1707 Roscoe Street.

## A Constructive Plan for Financial Independence\*

By John H. Cooper, Yonkers, N. Y.

The Insurance Department of the State of New York has called to the attention of the author of the above-named article the fact that the article did not quote the correct rates of the company represented by him and also the fact that some of the statements were ambiguous. The author wishes to correct the errors and remove any misunderstanding as a result of insufficient detail and apologize to the readers of this publication, insurance agents and companies and to the Department of Insurance.

In Case No. 1, with the insured aged thirty-one and beneficiary aged twenty-seven, the contract referred to under "Program A" was an ordinary life contract for \$24,000 of insurance payable to the insurance company at death of insured under a trust agreement providing interest on the principal at the rate of  $4\frac{1}{2}\%$  and further providing for payments to the beneficiary of \$150 a month, consuming principal and interest in a period of twenty years. An additional premium is included for which the company agrees to pay an annuity of \$100 a month continuous to the beneficiary throughout her lifetime, beginning at the expiration of the twentieth year.

If the beneficiary dies before the end of twenty years following the insured's death, the payments will be continued to the estate until the twenty years have expired. In the event of total and permanent disability before attaining the age of sixty the insured will receive a life income of \$240 a month, and further premiums will be waived. The total premium for the above contract is \$508.96 per year.

The contract referred to in "Program B" is one providing \$24,000 of life insurance to the age of fifty-five. In the event of total and permanent disability before attaining the age of fifty-five the insured will receive a life income of \$240 a month, and further premiums will be waived. If death occurs before the age of fifty-five, the beneficiary will receive an income of \$1800 a year for twenty years and \$1200 a year beginning with the twenty-first year after death of the insured which will continue for the remainder of her life.

If the insured survives to the age of fifty-five, premiums will cease and the company will pay him an annual income of \$1,676.16 as long as he lives, guaranteeing to him or his estate \$24,000 minimum. The premium for this contract is \$878.96 a year.

The contract used in Case No. 2, with insured aged forty-five, wife forty-two and daughter seven, provided a total of \$50,000 of life insur-

\* A correction of the article appearing in the July, 1924, issue.

ance on an endowment form maturing at the age of sixty-five. In the event of total and permanent disability before the age of sixty-five he will receive an income of \$6,000 a year throughout the remainder of his life. If the insured dies at any time before attaining the age of sixty-five, his wife will receive \$2,000 in cash, and under the 4½% trust agreement with the continuous installment feature, for which an extra premium is included, the insured's beneficiaries will each be entitled to an income of \$1800 a year throughout their lives with a guarantee of twenty years' minimum total to each one. If the insured survives to the age of sixty-five, the company will pay him an income of \$5,000 a year throughout the remainder of his lifetime with a guarantee to him or his estate of ten annual payments. The annual premium for this contract is \$2,815.40; the single premium \$34,555.20.

35 South Broadway.



## PRACTICAL HINTS

This department is in charge of V. C. Smedley, D.D.S., and George R. Warner, M.D., D.D.S., 610 California Building, Denver, Colorado. To avoid unnecessary delay, Hints, Questions and Answers should be sent direct to them.

NOTE—Mention of proprietary articles by name in the text pages of the DENTAL DIGEST is contrary to the policy of the magazine. Contributions containing names of proprietary articles will be altered in accordance with this rule. This Department is conducted for readers of the DENTAL DIGEST, and the Editor has no time to answer communications "not for publication." Please enclose stamp if you desire a reply by letter.

### *Editor Practical Hints:*

I have been reading your Practical Hints with much satisfaction and enlightenment, and know I derive much benefit from them.

I have a young lady patient, age twenty-four, who since the extraction of a lower right first molar complains of a creaking or cracking sensation in her condyles every time her jaws are opened. She says the extraction was very hard, but there seems to be no displacement, and her articulation is perfect. There is no pain present, only the noise and the embarrassment. Will thank you in advance for any information you may be able to furnish me as to a remedy or cause.

E. D. K.

ANSWER.—You apparently have a case of traumatic arthritis of the temporo-mandibular joint. These cases are apt to be very persistent. It is impossible to put the joint at rest, and use seems to make the condition worse. The condition is also aggravated and even caused by infection, therefore you should see that there is no infection in the mouth, paranasal sinuses and throat. The patient should be warned to be careful about putting any unnecessary strain on the jaw, to be careful about yawning too wide, or opening the mouth too wide for any purpose. Topical applications over the area might help, although after an elapse of time they would be of doubtful benefit.

—G. R. WARNER.

### *Editor Practical Hints:*

I have patient wearing full red rubber denture who has complained (since plates were inserted) of gums puckering and annoying him.

Removed two roots, but he gets no relief. Says gums still seem to draw. Patient inclined to be nervous. Please advise.

F. M. H.

ANSWER.—There are undoubtedly some cases where red or any other pigmented rubber can be positively irritating to gum tissue. Black or natural base rubber is the least irritating quality of rubber. Metal bases, preferably gold or platinum, are undoubtedly best and in all probability would obviate this difficulty. I would suggest also that ample relief be provided over the posterior palatine and anterior palatine foramina and their distribution areas. The occlusion should be carefully worked out also to obviate any shifting of the plates in function and consequent trauma of the supporting membrane.

We have had a lot of discussion of this particular subject within the last few months and many valuable suggestions have been presented. The subject was up for discussion at the last annual meeting of the National Society of Denture Prosthetists, where it seemed to be the general opinion that there are some cases where the difficulty cannot be obviated entirely through a purely mechanical procedure such as the selection of material, method of adaption, etc., but that the condition is essentially a systemic disorder and can be corrected only through the reestablishment of normalcy in the general system, especially the nervous system.

Decided benefit or complete relief can frequently be obtained through a correction of the dietary habit, usually calling for a reduction of the quantity of food taken into the system to the actual body requirement with the elimination, to a considerable extent, of heavy, starchy and protein factors, with substitution of food richer in mineral and vitamine content, such as fresh green vegetables, fruits, milk, etc. It was also brought out in this discussion that most of these cases of drawing and burning pains in edentulous mouths will be found to be women at the period of the change of life, and if relief cannot be obtained during this period, after it has passed and a general balance of health has been reestablished, this annoying mouth condition frequently subsides.—V. C. SMEDLEY.

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*Editor Practical Hints:*

I wonder if you can give me a little help in a problem that bothers me very much. It's an inlay problem. I find that I can carve my occlusion and reproduce cusps and sulci very well, but in the finished inlay I lose very often the nice lines when I come to polish.

Can you suggest a means of overcoming this difficulty? I have



received many hints from your "corner" of the *Digest*, and hope that your elucidation of this difficulty may help others as well as myself.

C. J. H.

ANSWER.—This is a difficulty that is very annoying to every conscientious operator. While it cannot be entirely obviated in any practice, it may be largely minimized by having the patient chew with a grinding motion on the wax, both before and after carving, to make sure that the wax is not too full at any point. Then when the carving is complete go over the surface with a pellet of cotton moistened slightly with oil of cajeput. This will produce a very smooth surface of the wax which, if the investing and casting process is carried out without fault, bubble or blemish, there is comparatively little polishing to be done.

The inlay should be fitted into the cavity and tested carefully with carbon paper for any possible points of excessive contact which should be ground for relief, then remove the inlay and put a final polish on the occlusal as well as the approximate surfaces with the inlay in the hand. It is easier to get into the various grooves and fissures to polish with less destruction of the fine lines of carving with the inlay out and in the hand, than while working in the mouth.—V. C. SMEDLEY.

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*Editor Practical Hints:*

About four years ago I made full upper and lower dentures of vulcanite for a lady about 55 years old.

Recently she called and said the dentures were comfortable, but did not wear them constantly for the reason of excessive deposits of tartar on them. On examination I found large deposits of dark brown stains and tartar.

Patient claims to have treated for this condition with several physicians, but with no relief.

I would appreciate any suggestions you could offer me in this case.

A. S. B.

ANSWER.—I see no reason why this lady should refrain from wearing her plates because of the tendency to deposits of tartar. This cannot collect if she will brush the surfaces vigorously two or three times a day, but if it does get ahead of her and begins to accumulate she can remove it easily by soaking the plates for from ten minutes to a half hour in fifty per cent solution of Hydrochloric or Sulphuric acid after which it will brush off very readily.

If she wishes to correct the tendency to tartar formation within her system, this she can do by a careful regulation of her diet: by taking a much less quantity of food and by selecting what she does

eat with a larger proportion of fresh vegetables and fruits, both in the form of salads and cooked, and a less proportion of meats and starches, especially bread and other things made from white flour.—  
V. C. SMEDLEY.

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*Editor Practical Hints:*

As a reader of DENTAL DIGEST, and taking great interest in "Practical Hints" department, am writing for a little information.

A patient was referred to me (a sea captain) who has had three plates made (upper), but they are of no use to him on account of the sensitiveness of the roof of his mouth. If he tries to eat with them he gags, if he talks to anyone for a few minutes he gags, if he smokes his pipe with them he gags; in other words, he is more comfortable without them. The three plates were made by good men with different ideas, but they were not successful in giving him the use of them, although they all fit nicely. He says candy is the only thing that he can have in his mouth all day without the plate bothering him. He is sensitive to the appliance of a ball-burnisher on any part of the roof of the mouth, especially at the nerve centers (posterior palatine and anterior palatine). Is there anything that can be done for him, so that he can wear a plate with comfort, and have the use of it at meals?

Thank you in advance for any information you can give.

G. R. M.

ANSWER.—It is very rarely indeed that a patient's palate is so sensitive that he cannot wear a full plate if the plate really does fit up firmly clear across the distal periphery, if the posterior border is located at the exact junction of the hard and soft palate, if the edge is nicely tapered to a feather edge and highly polished, and if the patient will do his part in a reasonable effort to persist in wearing the plate. If all these features of the plate he now has are as above I think I would advise that you attempt to fit his mouth with the palate uncovered.

A rim or roofless plate can be made in many upper mouths, if not in most, by making an impression following closely the modeling compound technique described in Professional Denture Service for lower dentures. With such a rim or roofless denture you cannot, of course, expect the stability or retention in support that are procurable where the entire palate is covered, but many people are wearing this type of denture with a high degree of comfort and satisfaction.—V. C. SMEDLEY.

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*Editor Practical Hints:*

I wish your advice and opinion concerning my baby's teeth. He is

9 months old and in perfect health. He has his centrals and laterals below, and centrals above are just through good with a considerable space between them. My family history has never shown such, nor my wife's. What is the most logical thing to do? Do you think they will eventually grow together?

V. C. L.

ANSWER.—It is not an uncommon thing to have the maxillary central incisors erupt with some considerable space between them; of course there is always the possibility of the absence of laterals in the permanent set, but I don't know that I have ever seen a case where they were absent in a temporary set. It wouldn't be a difficult thing to make radiograms and determine this, other than that it would seem to me that the logical thing to do is to wait and in all probability, as the laterals erupt, the centrals will come together, or nearly so.—G. R. WARNER.

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*Editor Practical Hints:*

I replaced two teeth on a rubber plate. The repair was good. No porous rubber in the old rubber or new, but on unflasking of the plate I found there was a hole between the bicuspid tooth (replaced by me) and the median line of plate. Looked as though someone had punched a hole through plate with the small end of a walking cane. I attended to the vulcanizing myself. The thermometer registered 320° for 45 minutes. Soon as the time was up I turned out the fire under vulcanizer and held the vulcanizing pot in a pail of water to cool it off quickly. On opening the vulcanizer I noticed the water was saturated with plaster. On opening the flask I noticed that something like an explosion had taken place and the hole in the plate already referred to was the result of the explosion or expulsion of plaster in the flask.

I do not ordinarily cool my vulcanizer down in this way, but I have done it many times before and no serious or bad consequences occurred.

Could you or some of the DIGEST readers tell me the cause of the expulsion of plaster, and incidentally the hole in the plate?

Your answer will be greatly appreciated.

LEMUEL COLSON, D.D.S.

ANSWER.—This seems a very difficult thing to answer with any degree of assured accuracy, but perhaps some of our readers will have a more positive opinion for you.

It is my opinion that you probably started the vulcanizing process too soon after pouring the flask and before plaster had had time to

thoroughly set. You also might have enclosed a large air bubble in the flask just above the point where the hole was blown through your plate.

If you did not open the vulcanizer until the steam had condensed to water, and did not release the closure of the flask until same was thoroughly chilled, the rapidity with which you cooled the vulcanizer could not possibly have been the cause of this difficulty.

It might be that you inadvertently incorporated some foreign and incompatible substance in your plaster mix, something that prevented the normal setting of your plaster at this point and resulted in its expulsion or boiling out over this point in your plate, thus permitting or causing the rubber to thrust out into the space left by the dissolved or disintegrated rubber.—V. C. SMEDLEY.



# DENTAL LABORATORIES

## Advantages of the Laboratory to the Profession\*

By William A. Giffen, D.D.S., Detroit, Mich.

As I was present at the Boston meeting when this organization commenced to function, I assure you it is a pleasure to participate in this meeting and to see the progress made in such a short time, owing to the foresight of the few pioneers who started this Association. As President of the American Dental Association, I congratulate you and wish you every success!

I believe the dental profession is beginning to realize more and more each year the necessity of cooperating with the technicians. I have had enough experience with organization work to know that everything is not always rosy. It takes a lot of courage and perseverance on the part of those who work for better conditions to get results. In fact, it is like life itself—the first hundred years are the hardest!

First, I want to point out some of the difficulties in your plan, as I see them, all of which I am certain will be overcome in time, but it will take years. The whole problem is simply one of education of both the student of dentistry and the student of dental technic.

It is a waste of time to try to educate the dentist who has been in practice for a number of years to cooperate with the dental laboratory, as he probably has become so expert in his own opinion regarding his laboratory service that he is hard to satisfy; in fact, it is almost impossible—unless he has a specially trained technician, which is not practical from an economic standpoint. On the other hand, if the dentist is not of that exacting type, he is usually so careless in the preparation of his work before sending it to the laboratory that it is impossible to do satisfactory work for him. Again, a very small percentage of dentists are willing to pay for extra effort from their laboratory technicians.

My personal experience has been about as follows. I know dental technicians in my own city who can do the finest type of work. I have

\* Delivered before the American Dental Laboratories Association, Chicago, September 16, 1924.

been greatly pleased many times, but I always go over the case with them and explain just what I want done. However, in some cases the work is turned over to another person who does not understand what is desired; it goes through on a production basis and is not satisfactory to me. So I have learned that there are not enough discriminating dentists who are willing to pay for high-grade service, with the result that we simply "gum up" the organization of the laboratory when we send in special work. Therefore, in many of the high-grade offices the laboratory technic is done by specially trained technicians.

A few days ago I was talking with Dr. Charles Lane, the President of the National Society of Denture Prosthetists. I asked him his opinion of the future of commercial dental laboratories. Dr. Lane is a very fine technician himself, one of the best in the country, and has a very fine technician in his own office, trained by himself. He said that he had come to the conclusion that if technicians of ability were only properly trained, it would be unnecessary for any dentist to have a laboratory in his office. I am sure he is right, provided all dentists were able and willing to make impressions, models and measurements with accuracy and write out their specifications in proper form. If this condition prevailed, what a grand thing it would be for humanity, as they would receive a very much higher grade of dental service, especially in their restorative dentistry—and there will be plenty of that to do for at least a few hundred years!

In order to accomplish this ideal, we must cooperate so that the hundreds of dentists graduating each year may receive proper training which will enable them to do their operative work with precision, at least up to the point where it is turned over to the technician. As long as only a smattering of so many phases of the dental art can be given to the dental student, it is not to be wondered at that many of them never acquire precision in their methods.

Now, how about the technicians themselves? The vast majority of technicians who have become expert in their work have become so only by working many years in a haphazard way, picking up a little here and a little there. If they did not have both manipulative ability and brains, they made little progress. As a matter of fact, you gentlemen know, and I know, that a very large percentage of technicians get started in the work because they do not know what else to do and are willing to work for a very small salary. If they lack ability and brains, they continue on a small salary, while if they are smart (or think they are), they start a laboratory or a school of mechanical dentistry in a short time.

Now, to get down to the future prospects of your vocation—I am convinced that schools for technicians should be established in different parts of this country in which young men and women can be intelli-

gently and scientifically trained in a manner similar to the way in which our dental colleges teach their students. Those who lack the ability should be advised to seek another vocation, and some of the present "fly-by-night" institutions should be abolished.

Then, and not until then, can we expect to deserve progress and humanity expect to receive the restorative dentistry that will reflect credit upon the dental profession and the dental technicians.

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## Cooperation\*

By W. H. Schroll, Chicago, Ill.

Webster's definition of cooperation is: "a cooperating, concurrent effort or labor; the association or collective action of persons for their common benefit, especially in an industry."

Without cooperation no organization, be it large or small, can hope for any degree of success. We see around us large concerns in almost all lines of endeavor and by studying them carefully we find that cooperation has played a very prominent part in their development.

It is wisely said that "confidence is the backbone of all business." Don't do or say anything that would tend to destroy! Confidence is also the backbone of all cooperation. If we were all keyed up to 100% confidence, we should have perfect cooperation.

In my opinion, one of our greatest fields for cooperation is with our customers. We should bend every effort to build up confidence by giving them the very best that it is possible for us to give in the way of quality and service. If the proper confidence exists, it is an easy matter to teach the dentist to cooperate by giving good preparation and ample time to complete his orders in a satisfactory way.

I consider that I am cooperating with a customer when I turn down his poor preparation. It is true that in so doing you will occasionally lose a customer, but it is better to lose him before a large disputed account is outstanding. I find that very few resent a kindly word of advice, and those that do are generally customers that, when the credit report comes in, will be in the cash-in-advance class; while, on the other hand, the real dentist appreciates the interest you are taking in his business and is only too glad to cooperate by giving better preparation.

Many times a long distance telephone call is a splendid investment in the way of cooperating with a customer and getting things going smoothly.

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\* Delivered before the American Dental Laboratories Association at Chicago, Ill., September 15, 1924.



One of my favorite ways of getting a customer to cooperate with us is to get him into our laboratories. I then go all over the entire organization with him. I explain details as to the kind of materials used and manner of construction, as well as the way the work is received and the orders are entered, being sure to specify just where his orders are entered, checked and packed. I usually find that some little detail somewhere along the line makes a "hit" with him and quite often he asks if his preparation is what we want. I always do my best to make a customer feel at home in our laboratories, and if he shows a special interest in any particular line of the work, quite often I give him a chair and let him visit with the man or men who handle his work.

In visiting with customers many times I pick up some very good points. Just recently a suggestion from a customer who visited our office changed our way of wrapping our work.

When I mention service in connection with cooperation, I do not mean that it is necessary to rush out, pick up a doctor's order, hurry it back to the laboratory, slam the work through, have a man work overtime to get it out and keep a boy late to get it back to him in a hurry! This, of course, could be classed as special service, but it should be practiced only occasionally for the reason that in our business rushed work is not very satisfactory. Then, again, overtime work is something that most men do not like. There are times when it is necessary for us to work a few hours overtime if we are to cooperate with our customers and not hold their work too long, but if the workmen throughout an organization are really cooperating, help can be shifted from one department to another and in this way overtime work can be avoided.

Some may say that their men do not like to go from one department to another, or that they do not understand the work. Then the manager of that organization has not trained his men to cooperate. I do not mean by this that all the help should be all-round men and able to work anywhere, but the help should be flexible so that one department can assist another. This applies as well to the office.

I have heard many owners say that their men are glad to work overtime because they like the extra money. Do not think just because a man always says "Yes" when he is asked to work overtime that he always wants to! He may be really loyal and want to do everything he can to please you, or he may have said "Yes" through fear that he might lose his position if he did not comply with your request.

We find that a department that works overtime does not turn out so well the following day, and also that the workmanship is not so good.

If we are to cooperate with our customers, we must be sure that we have an organization that is cooperating within itself. If the offi-

cials, the department heads and the different departments are not all cooperating, we are not getting the best results. Furthermore, we must have teamwork and cooperation in every department.

It is my candid opinion that a successful manager will insist upon 100% cooperation and will "fire" the ones who will not cooperate. This may seem to some to be a rather rough way of handling matters of this kind, but we usually find that in the end it is the best method for all concerned. An employee who will not cooperate is not entitled to much consideration. He not only blocks efforts to serve customers but sets a bad example to other employees.

This cooperating within ourselves is not all a one-sided affair. If you expect to get results, you yourself must first show a spirit of cooperation. If you give a man more work than he can handle, if you do not give him the proper tools or the proper materials, you cannot expect him to get the best results.

Remember, you are the one who is making that position, and if you expect to get the best, you must give the best. A man should be paid a fair wage; a contented, happy employee will always get the best results.

We should also not lose sight of the fact that we should cooperate with the dental dealers. This applies especially to those of us who call on the dealers for service at the tooth counters. We should not require \$10.00 worth of service on a \$20.00 purchase.

The same thing applies to precious metals. If your metals are not working right, get in touch with the manufacturer. The chances are 99 to 1 that he will make them right.

Likewise, we should cooperate with the telephone company. No business telephone should be used for visiting. We always call any employee to the telephone, but we do not allow a long conversation. It leaves a bad impression on the customer if he finds it out.

You must remember also that even your mail service will not function properly if you do not cooperate with the authorities. How often do you ask the Post Office what you can do to help your service? Do you always make it a point to get the mail to the Post Office as soon as it is finished? I mean by this—do you check out and pack your mail orders as fast as they come out or do you hold them until night? Do you forget the Post Office is working all day and that your packages get better attention during the day than they do around seven or eight o'clock in the evening? We aim to have all our mail in the Post Office before six o'clock.

Do you make an earnest effort to get your delivery boy out as early as possible? You know the earlier he gets out the sooner he delivers your orders and also the sooner he gets back with his pick-ups. Did you ever ask an errand boy how he could give your customers better

service and in this way serve you better? There is a very good saying on a calendar issued by a large advertising concern, which reads: "We ourselves the better serve by serving others best." It is quite true that the average errand or delivery boy in many instances does not use his head, but we might also say the same thing of grown-ups.

One of the greatest evils practiced among dentists is to call for a boy and then not have the work ready when the boy gets there. He will tell the boy to wait. If the boy fails to use the proper language in explaining to the doctor that he cannot wait, the chances are that the doctor gets "sore" and calls the laboratory. Then whose part do you take? The customer must be first considered because he is the one that signs the checks, but you should not make the boy the "goat" because the chances are you have told him never to wait. This is a time for the dentist to cooperate with the laboratory. Too many dentists take advantage of free service. If they were to pay for it at the same price it costs us, you would be surprised at how your calls and deliveries would drop off.

If our organizations are cooperating within themselves, our customers are cooperating with us and we with them, our supply houses are cooperating with us and we with them, some of us may think our circle is complete; but, my friends, it is not. We have left out one of the most vital factors—our competitors.

Remember, only a few years ago we thought all our competitors were crooks and criminals. We never spoke to them—much less went to see them. How foolish and childlike it all seems now since we know one another a little better! I remember that only a few years ago we should never have thought of going to lunch with a competitor, and to call one up and ask a favor was unheard of.

When the old National Dental Credit Association was formed in Chicago about ten years ago, we could not make it function 100% because of the lack of confidence. I will say, however, that several of us who stuck and worked together are all very glad that we did.

Some will say, "What good is an association?" Surely no up-to-date business man will make a remark of this kind. He knows there is an association for every industry, be it ever so small. Surely the dentists must look down upon us for not being better organized than we are. They have their American Dental Association with all its State and district societies, with their wonderfully efficient and magnificently furnished offices in Chicago, and with their Secretary, Dr. Otto U. King, in charge. Did it ever occur to you that the dentists are wondering what is the matter with the laboratories?

Why did the program committee of the Englewood Dental Society come and ask us to organize so that we could cooperate one with another? It was because the dentists knew we needed an association in order to

promote and advance the science and art of mechanical dentistry, to cooperate with the dental profession and to provide, through the dental laboratories, for the dissemination of knowledge concerning this subject and to encourage the study of the various phases of this specialty.

We all know that in going through dental school the student is not taught much of the mechanical side, and we should have our customers visit in our laboratories and become familiar with the different methods used. We should have no secrets in our business.

There is really nothing so disconcerting to me as to hear a man say that he cannot afford the expense of the association. He is "penny wise and pound foolish." He has not studied the working of associations. I wish we had an association that would cost us five times as much as it does and that we had every laboratory in the United States as a member. If this could be accomplished we would see dentistry, both mechanical and operative, show as much progress in one year as it does now in five. Why? Because the dental laboratories today are a millstone on the dentist's neck. They are doing practically nothing to make better dentistry. About all they are thinking about is the almighty dollar, and about the only time the word "quality" enters their minds is in writing a letter or getting up an advertisement.

What we want to do is to get together often, get well acquainted, build up a confidence and develop it into a real association, something that we shall all be proud of, and we shall find the American Dental Association reaching out to give us the glad hand of fellowship.

This is the kind of cooperation we need to build up our standards so that we can render a real service, turn out modern restorations and cooperate with the profession in giving the public better dentistry. The public in turn will be glad to pay better fees, the dentist will pay us better prices, and we can all afford to pay our dues.

Again I say, remember the definition of cooperation: "the association or collective action of persons for their common benefit, especially in an industry."

*My* definition of cooperation is: "the working of all together in a friendly way."

My friends, we all need cooperation; we all need an association. Let's all get together and put our shoulders to the wheel for better dentistry.

5 South Wabash Avenue.



# DENTAL SECRETARIES and ASSISTANTS

## Secretaries' Questionnaire

All questions and communications should be addressed to Elsie Pierce, care of THE DENTAL DIGEST, 220 West 42nd Street, New York City.

We are in receipt of a letter for "G., Middle West," whose story appeared in the questionnaire of January, 1924. If she will send her present address to this department the letter will be forwarded.

The widow of a dentist writes us the following letter. We feel that its publication will be of interest to our readers and we shall welcome their opinions.

*I have worked in a dental office over twenty years doing the prophylactic work, laboratory work, and assisting at the chair. I am fifty, but in perfect health, and have in all probability at least fifteen years of efficient labor ahead of me. I have had more than unusual success in plate work. It has always been my duty to take the plate from the time the impression was taken and complete it—set-ups, try-ins and final adjustments. My ratio of troublesome plates is far below the oft-time stated ratio of one in twenty-five. I have often taken the impressions.*

*Now here are some of my faults. My work lacks the perfect finish of commercial laboratories. I am slow and cannot produce a plate in the time they do. My carving is not so perfect or rapid. In other words, I cannot compete with finished laboratory workers. As purely an assistant I would not appeal to the average young graduate because he prefers a young girl; on the other hand, I am considered an asset because of my work and personality in meeting people.*

*Now, here is the question: Is there a reasonable opening for one of my age and capacity? Should I stick to my laboratory work and go to a laboratory school and acquire more perfect training and modern ideas? Would there be openings in laboratories for me? Would there be openings in offices where they would appreciate my training in*

*laboratory technic and years of experience as a chair assistant? Or should I go to a business college, take a review of my old commercial work and seek a position in the business world? A banker has told me that my mature appearance was an asset and not a hindrance in his field and other business fields.*

*After this coming spring it will not matter where I locate. Will you advise me frankly? How long and where should I need to go to get my training? What would the probable salary be and the chance for a position? Do you advise a course in Oral Hygiene? What would the openings be along that line? The expense, etc.? Or do you advise, from your knowledge of chances for a mature woman in laboratories and offices, against going on in the dental profession? I like the work.*

*I thank you for any information or suggestions you can give me.*  
T. B. R., Northwest.

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May I tell you how pleased I am that the questionnaire has made its reappearance in THE DENTAL DIGEST. I am glad to send you the following suggestion for cotton roll swabs. In our office we purchase the different-sized cotton rolls by the box of 500. I cut them in varying lengths *on the bias* instead of square across. This gives two pointed ends that can be used in the smallest spaces and sockets. I know this will help the work of the assistant, especially in a surgical office.

F. W., Phila., Pa.

I am a dental secretary and am pleased to contribute the following idea for the keeping of the returned cancelled checks from the bank. When I took this position the doctor and previous secretaries had been rather careless in the keeping of returned vouchers. They were scattered all over the office, in desk drawers, closets, boxes, etc. One day it was necessary to find a cancelled check and we had a merry hunt for it. I now paste all the cancelled vouchers back in the check book the day they are returned from the bank, so that they correspond with the stubs. It takes only a few moments and when the book is used up all the cancelled checks and stubs are together. No more hunting for lost vouchers!

A. H. S., Brooklyn.

*Would you kindly send me some information regarding a course in Dental Secretary and Assistant work?*

D. W., Westfield, N. J.

There is no school at present in the East giving such a course. Two Western universities give a combined course in Dental Hygiene and

Assisting, but no doubt these would be too far away for you to attend. Why do you not join a dental assistants' society? Classes in various phases of instruction, as well as clinics relative to the work of the dental assistant, are given to the members and you could learn much in this way.

## January Meeting

OF THE

EDUCATIONAL AND EFFICIENCY SOCIETY FOR DENTAL ASSISTANTS,  
FIRST DISTRICT, NEW YORK, INC.

The regular monthly meeting of the Educational and Efficiency Society for Dental Assistants was held on Tuesday evening, January 13, 1925, at the Academy of Medicine, 17 West 43rd Street, New York City.

The president, Juliette A. Southard, opened the meeting by extending her cordial New Year's greeting. She then departed from the usual procedure, turning over the gavel to one of the members, Miss Emily Campbell, who presided as chairman for the evening.

After the reading of the minutes and the treasurer's report, the various standing committees were heard from. An announcement was made that the Clinic Club would clinic before the First District Dental Society on Monday, February 2nd, at 4 P. M. The chairman of the classes announced that the Laboratory Class had been successfully completed and the Public Speaking and Parliamentary Procedure Class was under way, the first meeting taking place Thursday evening, January 22, 1925.

After introducing several new members, Miss Campbell extended to them a cordial welcome, expressing the hope that they become earnest and ardent workers.

The Society was then favored by a most delightful and informal talk by Dr. Winifred Sackville Stoner on *How You Can Help Progress*. Dr. Stoner gave the Society the first lesson in Esperanto, the universal language. In her talk she reminded the members that tact and cheerfulness always win. They must be adaptable and ready to learn all things. A rising vote was tendered Dr. Stoner for her most interesting talk.

Dr. Joseph A. Burgun, President of the Second District Dental Society, addressed the Society on the subject of *Intelligent Service, the Goal of the Dental Assistant*. In order to render more intelligent service, she must first learn two things: "Why?" and "How?" "Why is it done?" and "How can it be done better?" She must read to



keep up with the times, make friends in her line and constantly look ahead. She should be the silent understudy of the dentist, learning by watching. Coupled with ambition, she cannot but succeed.

The business man in order to be successful must sell. No matter what his merchandise, he cannot profit unless he sells it. The dental assistants' commodity is "Service." To realize that in rendering service one can become almost indispensable is a feeling that should warm the heart and repay one for any effort expended.

Dr. Burgun tabulated the many ways in which an assistant can aid and relieve the dentist and the time she can save him in these tasks. She can relieve him of five hundred tasks during the week, thereby enabling him to spend his evenings in mixing socially and to forget the cares of the office instead of working overtime.

Dr. Burgun also stressed the necessity of neat appearance and adaptable character. The patient's first meeting is often with the assistant, and not with the dentist. Make first impressions favorable.

Emily Campbell called upon the Society for a rising vote of thanks to Dr. Burgun and then turned the chairmanship back to the president.

Delegates to the meeting of the New York City Federation of Women's Clubs were elected.

Dr. Henry Fowler, who has been instructing the Public Speaking Classes during the past few years, spoke a few words about the class newly formed. It helps one to gain confidence in the open meeting in speaking and taking the initiative.

Dr. Herbert Wheeler spoke a few words of greeting. A letter of greeting from Helen Johnson, former executive chairman, was read by the secretary.

Agnes MacNeil made an announcement of the Entertainment and Dance to be given at the Hotel McAlpin, Wednesday evening, January 28, 1925. Members were urged to make this a success.

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## Meeting

OF THE

EDUCATIONAL AND EFFICIENCY SOCIETY FOR DENTAL ASSISTANTS  
OF MASSACHUSETTS

The first meeting of the season of the Educational and Efficiency Society of Massachusetts for Dental Assistants was held in Salem in the office of Dr. Joseph Le Blanc on Tuesday, January 13, 1925.

The speaker of the evening was William H. Canavan, D.M.D., of Boston City Hospital. He gave the girls a heart-to-heart talk on

the dental assistant from the standpoint of the dentist. Dr. Canavan laid particular stress on the following points in his talk: That above all a girl must be loyal to her employer; that to get best results a certain routine must be followed in office practice, each having his or her own duties to perform in regular order; that personal cleanliness was most important; and that an assistant must have ambition to help the dentist to turn out the best possible work at all times. Dr. Canavan's experience in connection with the Boston City Hospital, training of nurses, etc., enabled him to give the girls much valuable information.





## EXTRACTIONS



No Literature can have a long continuance if not diversified with humor—ADDISON

How to prolong your life—don't die.

The American youth's three R's are now readin', 'ritin' and radio.

The things that stand cold weather best are the polar bear, the reindeer and the feminine ankle.

A tutor who tooted a flute.  
Tried to teach two young tutors to toot.  
Said the two to the tutor:  
"Is it harder to toot, or  
To tutor two tutors to toot?"

A wife with a Good Samaritan complex is all right, except that she is forever yearning to give you medicine.

One is born every minute, and nearly all of them learn to sing "Sweet Adeline."

Solomon and David led very merry lives,  
And had a most delightful time among their many wives;  
But when at last their blood grew thin,  
They suffered many qualms,  
Then Sol, he wrote the Proverbs—and  
Dave, he wrote the Psalms.

Short Story—He thought she would give him half the road. Seventeen stitches were necessary.

(Nurse)—There's a man outside who wants to know if any of the patients of this lunatic asylum have escaped lately?  
(Doctor)—Why does he ask?  
(Nurse)—He says somebody has run off with his wife.

A traffic policeman is a Form of Perpetual Motion entirely surrounded by Carelessness. He is a man of two words: "Stop" and "Go," but he swings a white glove that can wigwag you right into the hoosegow unassisted.

He is the Judge Landis of the Delirious Flivver World, the Grand Commissioner of Disorganized Darting, the Czar of Flving Tinware, the Imperial Klearle of Crisscross Cavorting. He takes things as they come and disposes of them as they go.

Frail little automobiles shake their fenders off as they approach him and weak little operators get the tremors as they near his presence. He is bad news in a blue suit and white gloves.

### CALIFORNIA STUFF

There was a young man of Quebec,  
Whom they found stuck in snow to his neck,  
When they asked: "Is you friz?"  
He replied: "Yes, I is—  
But we don't call this cold in Quebec."

There's no need of accidents if you drive carefully and learn to read a jay-walker's mind.

One of the latest fads among women in England is a notch in the wedding ring to indicate a divorce. If that is adopted over here some women will be wearing circular saws.

You were once very great, Mr. Trotzky,  
But now you are nearly forgotsky.  
You were almost a Czar,  
But are now caviar—  
You would like to come back but  
cannotsky.

### ISN'T IT SO!

Sometimes I long for a lazy isle,  
Ten thousand miles from home,  
Where the warm sun shines and the  
blue sky smiles  
And the milk-white breakers foam—  
A coral island, bravely set  
In the midst of the Southern sea,  
Away from the hurry and noise and fret  
Forever surrounding me!

For I tire of labor and care and fight,  
And I weary of plan and scheme,  
And ever and ever my thoughts take  
flight  
To the island of my dream.  
And I fancy drowsing the whole day  
long  
In a hammock that gently swings—  
Away from the clamorous toiling  
throng,  
Away from the swirl of things!

And yet I know in a little while,  
When the first glad hours were spent,  
I'd sicken and tire of my lazy isle  
And cease to be content!  
I'd hear the call of the world's great  
game—

The battle with gold and men—  
And I'd sail once more, with a heart of  
flame,  
Back to the game again!

—Berton Braley.

# DIETETICS and HEALTH

## Dental Care for Children

At the present time the dental program of the Department of Health of the City of New York, as stated in the Monthly Bulletin, calls for the examination by a dental hygienist of the teeth of children in the 13 grades in schools where the dental clinics are located, with dental care for sixth year molar defects and other remediable conditions where this work is not apt to be done by the family dentist.

Several changes have been made in the forms used in these clinics during the year, so as to indicate more clearly the character of work done, results achieved, and to make tabulation easier. Dental hygiene, that is, prevention of diseased mouth conditions, continues to be the incentive for work in this branch. The few clinics operated by the Department cannot, of course, begin to care for the large number of children found with dental defects in the course of the year. Their true value may be said to be educational, in that they stress the importance of clean, sound teeth for a portion of the school population, in the hope that they will continue the work thus started, and spread the knowledge thus practically gained to their playmates and friends. It will never be possible for a city like New York to care for all of the mouth and tooth conditions found among its children. We must, however, persist in our educational program and feel certain that, in this way, we shall secure results just as we have in reducing the number of deaths from diarrhoeal diseases through maintenance of Baby Health Stations, and educational efforts, and in lowering the percentage of physical defects found among school children by the same means.

Every nurse doing school work has been instructed in the teaching of tooth brush drills so that all children in school—not only those who have had the advantage of attending a dental clinic—learn how to brush and care for their teeth. The educational measures adopted by the dental hygienists include group and classroom teaching, as well as individual instruction while the child is in the chair. Her prophylactic work also properly prepares each child for the dentist, so that the latter may work on a clean mouth. One cannot question the educational

value of thorough prophylaxis on children as a true preventive measure in reducing the number of decaying teeth.

Number of patients registered .....	18,590
Number of re-visits .....	36,379
Total visits to dispensary .....	54,969
Patients discharged .....	9,953
Cured .....	9,639
Dropped .....	314
Treatments .....	167,612
Temporary fillings .....	1,568
Permanent fillings .....	25,444
Extractions of deciduous teeth .....	19,922
Extractions of permanent teeth .....	4,426
Cleanings .....	20,229
Operations .....	84,460
Other cases .....	17,048
Prophylactic instructions: By dentist.....	16,869
By nurse .....	57,311
By dental hygienist .....	28,176

## Late Winter Dangers

During the late winter season there are atmospheric and dietetic conditions which tend to induce certain types of disease. In the North, particularly, the overdry air and insufficient ventilation predispose to colds and similar troubles. But even a greater danger is incidental to life in parts of the South, danger from the use of an unbalanced dietary, lacking in certain life essentials, according to an interesting article in "Life and Health."

Pellagra is a disease which shows itself in early spring, when the body for a long season has been deprived of such foods as milk, eggs, and fresh vegetables; when the diet perhaps consists of some such staples as corn bread, molasses, bacon, and the like. It is no longer commonly supposed that it is something in these foods that causes pellagra, but that the trouble comes from a lack of certain essential food elements, which are likely to be omitted from the diet in winter.

Experiments have been repeatedly made which show that the addition of the proper foods to the dietary will prevent and even cure pellagra, and other experiments have been made in which healthy prisoners, who were given experimentally a restricted diet for a time, developed symptoms of pellagra. Some have thought that pellagra is an infection, but these experiments, which have been very briefly men-

tioned here, indicate that a diet lacking in certain essentials is an important cause of the disease.

It is true that in some cases pellagra has attacked the well-to-do, who were able to have an ample supply of food at all times; but investigation into such cases has shown that those who suffered from pellagra were, for some reason, possibly from prejudice against certain foods or dislike for certain foods, depriving themselves of the foods mentioned above. They were on a restricted diet.

It is probable that many of the disabilities of late winter, including what is known as "spring fever," even when they are not accompanied by the rash and the violent digestive symptoms of pellagra, are milder manifestations of the same trouble, a kind of masked pellagra, caused by a diet which is ample in bulk, but which is lacking in certain essentials. The pellagra diet is characteristically a diet having an excess of starchy foods, especially the milled cereals, such as white flour and bolted cornmeal, and lacking in animal protein, such as milk, eggs, and fresh vegetables. The use of fresh meat will prevent pellagra, but meat is not essential if these other foods are present. It is after the diet has been lacking in such foods as these for a long time that pellagra commonly develops.

The lesson to be learned is that if it is necessary to economize, it is far better to effect the economies elsewhere, in the tobacco, tea, coffee, liquor, and other harmful indulgences, rather than to economize in the life-preserving foods.

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### Facts About Chlorin for Colds

When the announcement first appeared in *The Journal*, last March, that Vedder and Sawyer of the Army Medical Corps had been able to devise a method for administering chlorin, in the treatment of respiratory diseases, which seemed to have a distinctly beneficial effect in this class of ailments, it was received with exceptional interest. This interest was stimulated, no doubt, by the fact that high officials of our government, including even the President of the United States, had submitted to treatment by this method and had expressed satisfaction with the results.

Immediately, individual physicians, as well as hospitals and health departments, undertook to test chlorin administration on a large scale, with a view to establishing finally its actual adequacy.

In New York City, Health Commissioner Monaghan established two clinics under the direction of Dr. L. I. Harris, in charge of the Bureau of Preventable Diseases. These clinics began active work June 1, and continued until August.

The results of the experiment have just been made available

through the health bulletin of the Department of Health of the City of New York. According to the report, only 6.5 per cent of 506 persons with various respiratory diseases reported themselves as cured, in contrast to 71.4 per cent of 931 patients reported cured in the original paper of Drs. Vedder and Sawyer.

Fifty-three per cent of the patients treated by the New York clinics reported improvement, but the physicians in charge do not attach much importance to such reports, since it is well known that patients with minor respiratory infections tend to improve, within certain limitations, by the very nature of such diseases. As is mentioned, the report of the New York investigators concerns only acute cases, and the conclusion is that in such instances at least the claims are justified.

Much has been said of the use of the method in whooping cough, but eighteen cases of this disease studied with twelve controls failed to show any appreciable advantage of the chlorin method of treatment over that previously used.

The method was without apparent benefit in asthma and in hay-fever; indeed, three patients with asthma became decidedly worse under treatment.

The results of this controlled investigation are, therefore, such as to deprecate definitely the claims originally made for the method by the Army medical investigators. The physician is confronted with a situation in which the original investigators, whose work seems to have been conducted in a scientific manner, report excellent results which other investigators working independently have failed to confirm.

Obviously, the results of numerous investigations being made elsewhere must also be brought to light before any opinion is warranted as to the future of this method of treating disease. Certainly the individual physician who purchases such apparatus and uses it in his practice must do so with the distinct understanding that he is using an unestablished method.

*—Journal of the American Medical Association.*





## FUTURE EVENTS

The next scientific session of the WESTCHESTER DENTAL SOCIETY will take place Tuesday evening, March 24, at the Yonkers Chamber of Commerce, 53 South Broadway.

The lecturer for the evening will be Dr. Leo Winter, Clinical Professor of the New York College of Dentistry.

Dr. Winter will talk on "Oral Surgery for the General Practitioner" and will illustrate the lecture with lantern slides.

Drs. J. E. Berger and I. Linder will discuss the paper.

The February meeting was addressed by Dr. Wm. H. Leak, formerly head of the Oral Hygiene Committee of the State of New York. Dr. Leak spoke on "Care of the Teeth during Pregnancy and Early Childhood." This meeting was also attended by many local medical practitioners.

Drs. Howard Cheney and Louis V. Waldron discussed the paper.

DR. SIMON MILLER,  
Room 206, Flagg Bldg.  
Yonkers, N. Y.

The next meeting of the NEW YORK STOMATOLOGICAL SOCIETY will be held on Monday, March 30, 1925, at 2 P. M., at Aeolian Hall, 33 West 42nd Street, Suite 1538, New York City. There will be a symposium on Root Canal Practice by Drs. Taylor, Ruggier, Asgis, McDonald, Shera and Slocum. Members of the dental and medical professions are invited to attend.

DR. STANLEY SLOCUM, *President*  
DR. F. W. McDONALD, *Secretary*  
33 West 42nd St., New York City.

THE ALABAMA DENTAL ASSOCIATION will hold its next meeting in Mobile, Ala., April 6th to 8th, 1925.

F. F. PERRY, *Secretary*,  
Montgomery, Ala.

The sixty-first annual meeting of the CONNECTICUT STATE DENTAL ASSOCIATION will be held at the Central High School Building, Hartford, Conn., April 30, May 1-2, 1925.

CHARLES W. ROBERTS, *Hartford, President*,  
S. E. ARMSTRONG, *New Haven, Secretary-Treasurer*.

The next annual session of the PENNSYLVANIA STATE DENTAL SOCIETY will be held at Reading, Pa., May 5-7, 1925.

A. C. BARCLAY, *Secretary*,  
914 Highland Bldg., Pittsburgh, Pa.

The next annual meeting of the NORTH DAKOTA STATE DENTAL ASSOCIATION will be held at Fargo, N. D., May 5-7, 1925.

L. R. McLAIN, *President*,

F. B. PEIK, *Secretary*, Carrington, N. D.

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The fifty-eighth annual meeting of the TENNESSEE STATE DENTAL ASSOCIATION will be held May 5-7, 1925, at Knoxville, Tennessee.

J. B. JONES, *Secretary-Treasurer*,

Murfreesboro, Tenn.

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THE DENTAL SOCIETY OF THE STATE OF NEW YORK will hold the fifty-seventh annual meeting at the Hotel Ten Eyck, Albany, N. Y., May 13, 14, 15, 1925. All literary exercises, clinics and exhibits will be staged at the Hotel Ten Eyck.

The Society extends a cordial welcome to all ethical dentists.

Make reservations early at the Hotel Ten Eyck.

Exhibitors are requested to address Dr. E. W. Briggs, 1116 Madison Avenue, Albany, N. Y., for space.

A. P. BURKHART, *Secretary*,

57 East Genesee Street, Auburn, N. Y.

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THE DENTAL HYGIENISTS' ASSOCIATION of the State of New York will hold its fifth annual meeting at the Hotel Ten Eyck, Albany, N. Y., Friday and Saturday, May 15-16, 1925. A cordial invitation is extended to all ethical dentists and hygienists to attend the sessions and clinics.

HARRIETT PLUMSTEAD, *Acting President*,

184 Joralemon St., Brooklyn, N. Y.

HELEN R. DONAHUE, *Secretary*,

Bloomington Hospital, White Plains, N. Y.

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The thirty-eighth annual meeting of the ARKANSAS STATE DENTAL ASSOCIATION will be held at the Marion Hotel, Little Rock, Arkansas, May 25-27, 1925.

H. J. CRUME, *Secretary*,

212 Armstrong Building, Little Rock, Ark.

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THE NORTHEASTERN MASSACHUSETTS SOCIETY will convene again this year at Swampscott, Mass., June 2-4, 1925.

HENRY I. YALE, D.M.D., *Sec'y.*,

Peabody, Mass.

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The next annual meeting of the COLORADO STATE DENTAL ASSOCIATION will be held at Colorado Springs, Colo., June 17-20, 1925.

H. B. TALHELM, D.D.S., *Secretary*,

502 Mack Building, Denver, Colo.

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The next annual meeting of the KENTUCKY STATE DENTAL ASSOCIATION has been changed to September 18-19, 1925, for a business session rather than for a regular program of April 6-8, 1925, as previously announced.

W. M. RANDALL, *Secretary*.